

L500
.W35
1966
no.8
1978

CALIFORNIA LEGISLATURE
ASSEMBLY

THE DILEMMA OF MENTAL COMMITMENTS IN CALIFORNIA

Prepared for
The Assembly Interim Committee on Ways and Means
Robert C. Crown, Chairman

SUBCOMMITTEE ON MENTAL HEALTH SERVICES

Nicholas C. Petris, Chairman (June 1966 – January 1967)

Jerome R. Waldie, Chairman (1963 – June 1966)

Frank Lanterman

Leroy F. Greene

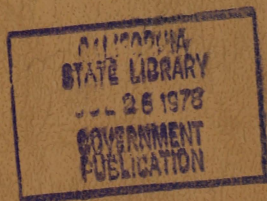
Charles W. Meyers

George N. Zenovich



First Printing 1967

5th Printing
Assembly Rules Committee
1978



"THE DILEMMA OF MENTAL COMMITMENTS IN CALIFORNIA"

Prepared for
The Assembly Interim Committee on Ways and Means
Robert W. Crown, Chairman

SUBCOMMITTEE ON MENTAL HEALTH SERVICES

Nicholas C. Petris, Chairman (June 1966 – January 1967)
Jerome R. Waldie, Chairman (1963 – June 1966)
Frank Lanterman
Leroy F. Greene
Charles W. Meyers
George N. Zenovich



Staff

Arthur Bolton, Senior Consultant to the Assembly
William Barnaby, Legislative Consultant, Assembly Ways and Means Committee
Karsten Vieg, Special Consultant (April 1966 – January 1967)
Michael Nasatir, Legislative Intern (September 1965 – April 1966)
Gail Vessels, Committee Secretary
Connie Gebhardt, Secretary
Valerie Bradley, Research Assistant

Reprinted by the
Assembly Rules Committee
California Legislature
Sacramento

MEMBERS

LARRY CHIMBOLE
BILL LANCASTER
JERRY LEWIS
JOSEPH B. MONTOYA
HERSCHEL ROSENTHAL
BILL THOMAS

CHIEF ADMINISTRATIVE OFFICER
FREDERICK J. TAUGHER
EXECUTIVE SECRETARY
VALERIE VESCI

California Legislature

Assembly Rules Committee

ROOM 3016, STATE CAPITOL
SACRAMENTO, CALIFORNIA 95814
TELEPHONE: (916) 445-8173

LOUIS J. PAPAN

CHAIRMAN



June 30, 1978

FOREWARD

This is the fourth reprinting of "The Dilemma of Mental Commitments in California". The great demand for the report has been due, in part, to the continuing efforts of Assemblyman Frank Lanterman to improve mental health services in California as well as throughout the nation. Due to his dedicated work many other states have focused on the problems of the mentally ill and have found this report to be very helpful in restructuring their own services.

The report is the principal background document which led to the passage of the Lanterman-Petris-Short Act which has been described by many as the "Magna Carta for the Mentally Ill". The act established the most progressive and imitated commitment procedures in the country. Professionals working in the field have stated that California has made greater strides in the treatment of the mentally ill in the last few years than during the previous 100.

"The Dilemma of Mental Commitments" was originally published in 1966 as a background paper by the Assembly Ways and Means Subcommittee on Mental Health Services. In reprinting this report the Assembly Committee on Rules not only wishes to recognize the sustained interest in this report but to also express appreciation to Assemblyman Lanterman who will retire from the Legislature in December after 28 years service. He will be missed by his colleagues and by the thousands of mentally ill persons and their families who have benefited from his dedication, imagination, and intellect.

We are pleased to insure the continued availability of this valuable report through this printing.

ASSEMBLY COMMITTEE ON RULES

Louis J. Papan
Chairman

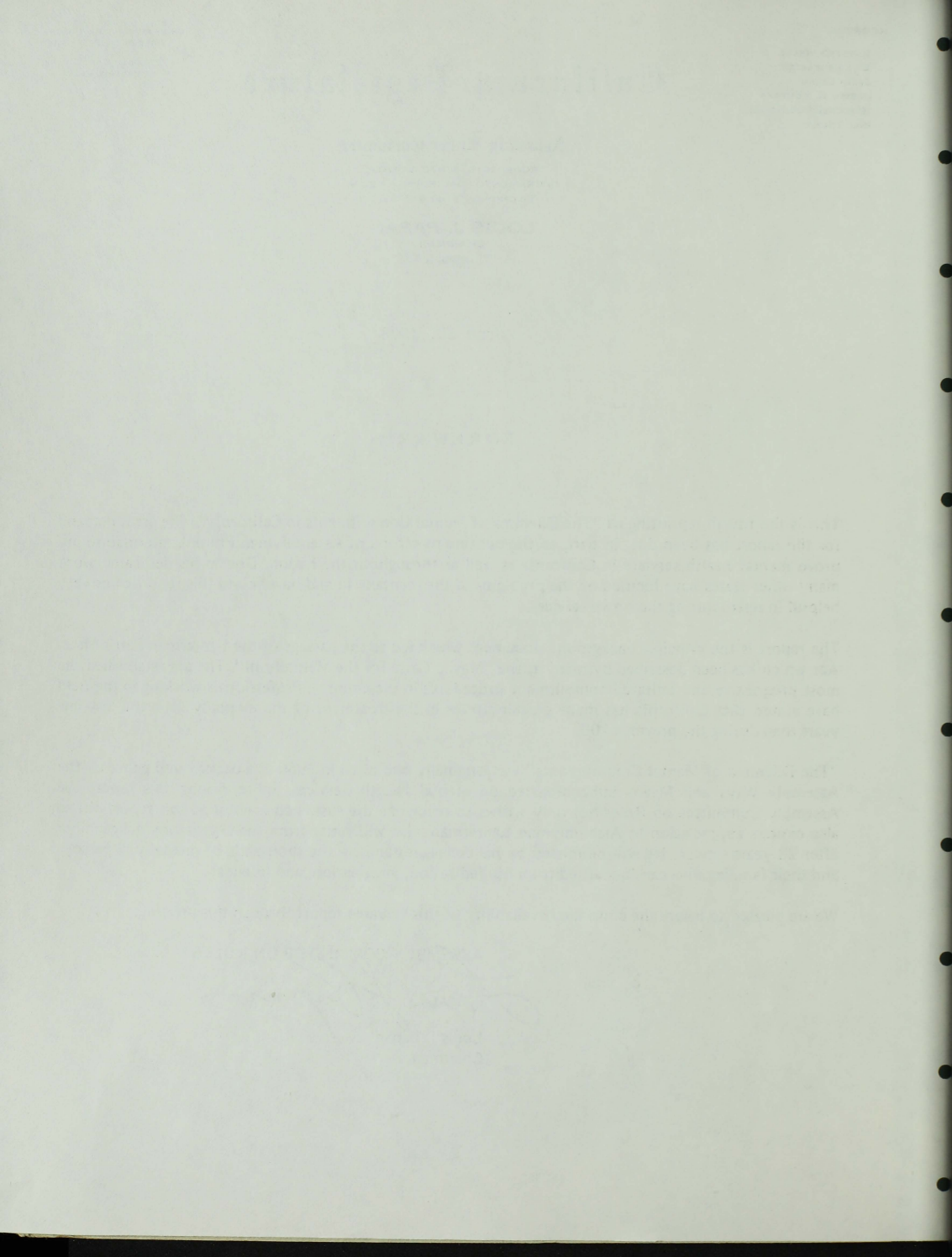


TABLE OF CONTENTS

	Page
INTRODUCTION	1
NOTE	5
CHAPTER	
I	
<u>THE BASIC DILEMMA</u>	
(Individual Health and Public Safety)	6
What is Mental Illness?	9
The Issue of Danger	14
II	
<u>THE COMMITMENT PROCESS AND LEGAL ISSUES</u>	21
1. The First Step - Detention	21
2. The Second Step - Diagnosis	27
A. The Qualifications of Medical Examiners	27
B. In Some Counties the Examination Is Made Under Very Trying Conditions	28
C. The Examination is Often Made Very Rapidly	29
D. The Possibility of a "Middle Class Bias" May Affect the Reliability of Diagnosis	33
3. The Third Step - Recommendations to the Court	38
A. Vague Criteria for Commitment	38
B. The Presumption of Mental Illness and the Tendency to Recommend Commitment	40
4. The Fourth Step - The Commitment Court	43
5. Legal Disabilities and Stigma Result from Commitment	51
A. Legal Disabilities	51
B. Quasi-Legal Disabilities	54
C. Stigma	56

CHAPTER		Page
III	<u>THE TREATMENT ISSUES</u>	61
	1. The Present Commitment System Frequently Leads to Ineffective Treatment in Psychiatric Institutions	61
	2. Hospitalization May Hurt Rather Than Help	70
	3. The Nonpsychotic Senile	77
IV	<u>RECOMMENDATIONS - PART A</u> (A Proposed New System for Citizens with Mental Disorders)	84
	1. Community Emergency Service Units	
	A. Functions of the Emergency Service Units	85
	1) Medical, Psychological, social, and legal evaluations as required	85
	2) Short Term Emergency Counseling	86
	3) Additional Services as Required	86
	4) Investigation and Clarification of Financial Resources	86
	5) Medi-Cal Inclusion	87
	6) Certification to Crisis Units	88
	7) Investigation and Protection of Person and Property	89
	8) Student Placement, Training, and Research	90
	B. Organization of the Emergency Service Units	90
	C. Administration	92
	D. Financing the Emergency Service Units	94
	2. A Variety of Available Services - On A Voluntary Basis	96
	A. Financial Access to the "Mainstream"	96
	B. Reducing Delay and Red Tape Barriers	97
	C. A Variety of Services	98
	D. The Division of Protective Social Services	99

CHAPTER IV	<u>RECOMMENDATIONS - PART A (Continued)</u>	Page
	3. Converting State Hospitals to High Quality Open Hospitals	100
	A. Changing the Staffing Standards and Financing Formula	100
	B. Converting to "Open Hospitals"	102
	C. State Hospital Release Policies and Post Hospital Services	103
	<u>RECOMMENDATIONS - PART B</u> (A Proposed System for Mentally Disordered Persons Who Are Criminal Offenders)	106
	A. Identifying Danger to the Community	107
	B. The Judicial Process	108
	1) Acquittal	109
	2) "Not Guilty by Reason of Insanity"	109
	3) "Not Competent to be Proceeded Against"	111
	4) Guilty	112
	5) Probation	113
	C. Special Release Procedures	114
	1) "Gravely Disabled Persons"	114
	2) The "Criminally Insane"	115
V	<u>DISCUSSION OF THE PROPOSALS</u>	117
	1. Emergency Service Unit Evaluations	118
	2. The Emergency Service Units in Rural Areas	120
	3. The Open Hospital	123
	4. The Problem of Converting State Hospitals	128
	5. Security Treatment Facilities	130
	6. Guardianship	133
	7. Civil Liberties and Involuntary Treatment	137
	8. "Potentially Dangerous" Persons	143
	9. Potential Suicides	152
	10. Alcoholics	156
	11. Current "Voluntary Admissions"	158
	12. "Short-Doyle" Programs	164
	13. Medi-Cal Financing	171
	SUMMARY STATEMENT	177
	APPENDIX	181
	BIBLIOGRAPHY	195

INTRODUCTION

Reflecting growing public awareness and concern over mental health problems, the Assembly formed a special unit in 1963 to examine California's established programs in this area and to recommend improvements as required. The Assembly Mental Health Services Subcommittee was set up under the parent Ways and Means Committee, and Assemblyman Jerome R. Waldie, Majority Floor Leader, was named chairman. Assemblyman Nicholas C. Petris and Frank Lanterman, both experienced analysts of state efforts in this field, were selected to complete the Subcommittee membership.

In 1965, the Subcommittee issued its first report, A Redefinition of State Responsibility for the Mentally Retarded, calling for regional diagnostic and counseling centers for the retarded and for alternatives to hospitalization in state institutions.

Legislation carrying out these recommendations was enacted during the 1965 Regular Session (A. B. 691), and two of the centers are now in operation--one each in San Francisco and Los Angeles--with more planned for the future.

During the latest interim, the Subcommittee turned its attention to California's system for handling the mentally

ill. This was initiated through a review of the court commitment process, the chief route through which patients enter state mental institutions.

A detailed analysis of services for the mentally ill was felt to be timely. This analysis is a logical continuation of the Subcommittee's earlier work. It is necessary because important advances in treatment concepts have occurred in recent years. But during this time the basic law governing California's system has remained unchanged in substance.

The presence of more than 25,000 patients in state hospitals for the mentally ill, despite declining commitment rates and shorter treatment periods, requires legislative examination. The fact that more than 1,000 people are being involuntarily committed to the direct care of the State each month further underlines the need for a reappraisal of existing practices in the light of rapidly changing mental health concepts.

In addition to the State hospitals, other psychiatric facilities in California contain thousands more, who have been involuntarily committed. The Subcommittee's one-day survey of psychiatric hospitals in California revealed that 84 percent of all persons resident in our state hospitals, 37 percent of V. A. hospital residents, 9 percent of the county hospital psychiatric residents, 17 percent of the

private or proprietary hospital residents, and 21 percent of the convalescent hospital residents were under involuntary commitment. Thus involuntary commitment plays a large part in the psychiatric treatment of many Californians--not just in the state hospital system.

Following Assemblyman Waldie's election to the U. S. Congress in June 1966, Assemblyman Petris was appointed Subcommittee chairman. At the same time, Assemblymen Leroy F. Greene, Charles W. Meyers, and George Zenovich were named to fill out the Subcommittee's membership.

In carrying out the study, the Subcommittee's activities have included public hearings, a review of relevant legal and mental health research and literature, and numerous interviews with persons connected with the mental health field either in an official capacity or through professional or voluntary organizations. Additionally, questionnaires were sent to 320 public and private hospitals caring for the mentally ill to survey such matters as their capacities, staffing patterns, treatment programs, and costs. At the same time questionnaires were administered to provide profiles of nearly 5,000 patients. Another questionnaire was directed to the commitment courts in 40 of California's most populous counties which, combined with many on-site observations, was designed to provide a comprehensive picture of commitment practices and how they vary among the courts.

All of these activities were undertaken with the aim of developing a working knowledge of contemporary thinking and a sound factual foundation on which to base the Subcommittee's recommendations.

The active cooperation and assistance of many persons in this study warrants special comment.

The Subcommittee extends its appreciation to the California Mental Health Association for their outstanding cooperation in administering the court questionnaire for the Subcommittee; to the State Department of Mental Hygiene and the California Hospital Association and all participating community hospitals for their complete cooperation in the hospital survey, to several prominent social scientists in California's universities and colleges, and to numerous legal and mental health officials throughout the State who participated in public hearings and gave countless hours to assist in this analysis of the mental health system.

- NOTE -

The Subcommittee contracted with the firm of Social Psychiatry Research Associates who assisted in designing the Subcommittee's surveys of courts and hospitals and who processed and analyzed the data.

At present there are over 40,000 psychiatric patients resident in State, V. A., private, proprietary, convalescent, and county hospitals in California.

The surveys collected data from a one-tenth sample of State (2,448) and V. A. (384) psychiatric hospital patients.

The surveys gathered data on a one-third sample of patients in private and proprietary facilities (824), county hospitals (211), and convalescent hospitals (573).

The survey gathered a total of 4,440 data sheets representing 34,104, or 83 percent of all hospitalized psychiatric patients in California--a highly representative sample.

Throughout the report reference will be made to these findings, and tables are to be found in the appendix.

CHAPTER I
THE BASIC DILEMMA

Under existing law,¹ mentally ill persons who can be involuntarily sent to state hospitals are defined as those meeting either one or both of two criteria:

- (a) Who are of such mental condition that they are in need of supervision, treatment, care or restraint.
- (b) Who are of such mental condition that they are dangerous to themselves or to the person or property of others, and in need of supervision, treatment, care, or restraint.

Implicit in these definitions are the two basic objectives of California's mental health system--individual health and public safety. And therein lies a basic dilemma.

While these goals need not always conflict, differences in emphasis have engaged the medical and legal professions in a continuous debate over which is more important, "civil liberties" or "treatment" considerations.

A review of recent legislative actions throughout the nation illustrates the tendency to make the process either

¹California Welfare and Institutions Code, Section 5550.

more medical, as in New York,² or to increase legal protections, as in the District of Columbia.³ This has tended to place state legislatures in the uncomfortable position of having to choose between the medical objectives of treating sick people without legal delays and the equally valid legal aim of insuring that persons are not deprived of their liberties without due process of law.

Put this way, it seems an impossible dilemma. Both positions are right and wrong and actions that further "medicalize" or legalize the present system are, at best, a poor compromise.

It should be noted that the psychiatric vs. legal argument is not completely polarized. Some lawyers and judges accept the medical view that legalities should be minimized in the commitment process "for the good of the patient"; and some psychiatrists are concerned about the lack of adequate due process in the commitment system.

²In the revised New York system (Chapter 738 of the Laws of 1964 of New York), the basic form of involuntary admission requires no legal proceeding at all and is accomplished by an admission certificate of two physicians accompanied by an application executed by a relative, friend, or designated public official.

³The new District of Columbia Code (Title 21, Chapter 5, Sections 21-501 ff. Supp. 1966) retains the pre-admission court order and requires a hearing before a court with counsel present in each case.

As a result, although state laws are intended to apply uniformly to all Californians, in practice the commitment laws are subject to a variety of interpretations and the commitment system varies widely from one county to another depending on the attitudes of the officials involved.⁴

The basic difficulty stems from the attempt to combine two very different social objectives--custody of the dangerous and treatment of the sick--into a single system. The result is a system in which it is difficult to achieve fully either individual health or public safety goals.

The commitment court can be seen in two ways.

Viewed the first way, it provides a legal process for removal of dangerous persons from the community to confined treatment facilities. If danger to the community is the issue and custody of the dangerous person the objective, then medical considerations are secondary. Danger must be substantiated by legal process, and confinement is required to protect the community and treat the offender. The commitment courts and the state hospitals are now expected to perform these protective and treatment functions.

Viewed the second way, the commitment courts provide a means of securing professional help for the mentally disordered

⁴See Appendix Table I for commitment rates by county.

who will not accept treatment. If finding mental illness is the issue and providing prompt treatment the objective, then legal considerations are secondary. Accurate medical and social evaluations are required to substantiate the nature of the problem and an appropriate treatment program is required. The commitment courts and the state hospitals are also expected to perform these functions.

It is unrealistic to expect to accomplish both legal and medical objectives within the commitment system.

Many legal experts say that the court should not confine people without trial. But most psychiatrists believe that legal process should not interfere with prompt treatment. We cannot have it both ways. The two objectives seem incompatible. The way out may lie in separate treatment and custody systems.

WHAT IS MENTAL ILLNESS?

The term "mental illness" is a nonscientific, generalized, popular label used to explain or describe a wide range of behavior which is considered "peculiar" or "sick", or "objectionable."

The behavior called "mental illness" is believed to result from three main causes:

- a. CERTAIN PHYSICAL DISORDERS, TOXIC CONDITIONS, OR INJURIES CAN AFFECT THE BRAIN AND A MALFUNCTIONING BRAIN MAY ALTER BEHAVIOR. (Some behavior called

mental illness is a symptom of disease. Just as some people have sick hearts or kidneys, others are literally "sick in the head.")

- b. PERSONALITY CHARACTERISTICS CAN INFLUENCE BEHAVIOR. (Some behavior called mental illness can also be considered as a special kind of learning problem. Some people have had personal experiences which have "taught" them to relate to other people in peculiar or objectionable ways.)
- c. ENVIRONMENTAL PRESSURES--SUCH AS PROLONGED DEPRIVATION, BATTLEFIELD PRESSURE, SUDDEN CHANGES FROM RURAL TO URBAN LIVING--CAN PRODUCE ATTITUDES AND STYLES OF BEHAVIOR WHICH DIFFER FROM THE NORM. (Some behavior labeled as mental illness results from people's reactions to cultural, economic, or other environmental pressures.)

Any one, or a combination of these three factors may cause a person to behave in ways which may be called "mentally ill" and some irrational behavior called "mental illness" occurs without any specific known causes.

It is also clear that the above-mentioned causal factors will not necessarily produce unusual behavior. Persons with diseases of the central nervous system, with difficult personal histories, or living under great pressures may, and quite often do, behave within the "normal" range. Reliable instruments for predicting how various individuals will react to stress do not exist.

The term "mental illness" does not describe any particular condition; it does not reveal the cause of any individual's difficulty, nor does it suggest any specific course of remedial

action.⁵ "Mental illness" is a catchall concept. It is a way of describing various kinds of behavior caused by a variety of known and unknown agents.

It is also evident that when a person's behavior is labeled "mental illness," those who do the labeling are guided by their own conceptions of what is normal and abnormal. Madness, like beauty, may exist in the eye of the beholder. It is also apparent that ideas about normality differ in the different cultures; and at different times in the same culture, behavior which was once considered normal may now be judged abnormal and vice versa. To further compound the problem of definition, certain types of activity are considered acceptable in certain situations or if performed by certain people but are considered odd or signs of mental illness if performed by other persons or in other situations (i.e., talking with spirits, fighting, killing, trances, idleness, intoxication, seclusion, nudity).

A review of relevant literature discloses that there is considerable controversy within the psychiatric profession

⁵"A principal error of the past was that a stereotyped approach was applied to the hospitalization of persons with all types of mental illness. As a result, hospitalization under formal legal procedures was imposed on a large number of patients who did not require such legal restraint--patients who could have received treatment on an informal, voluntary, or nonprotesting basis had the laws permitted." Group for the advancement of Psychiatry, Committee on Psychiatry and the Law, Laws Governing Hospitalization of the Mentally Ill, Report No. 61, May 1966, p. 148.

and among psychiatrists, sociologists, psychologists, social workers, and other mental health theoreticians regarding the nature of mental illness and appropriate forms of treatment. There is also considerable evidence that the instruments for predicting any individual's future behavior are still quite crude and unreliable⁶ and that the relative effectiveness of various treatment approaches has not yet been systematically evaluated and documented.

Despite all these uncertainties; despite the problems of definition, identification, and prediction; despite the questionable value of certain treatment programs; and despite the civil liberties problems, the general public, its elected representatives and civil servants have perpetuated the commitment court and mental hospital system as a means of disposing of a variety of disagreeable social problems. Dr. William Sheeley, a former state mental hospital superintendent and Project Chief of the American Psychiatric Association General Practitioner Education Project, describes the problem:

... the community's assumption is that the state hospital is a proper dump for its problem people. It

⁶"Psychiatry is the part of medicine farthest from a settled maturity, as strong as any in observation (perhaps even the richest, considering that social observations are so much better accepted in psychiatry than in most of medicine), and weakest in correlations and calculations." Leston L. Havens, M.D., Harvard Medical School, "Special Communication: Anatomy of Schizophrenia," JAMA, Vol. 196, No. 4, April 25, 1966, p. 119.

is an understandable, perhaps even forgivable assumption. But we dare not permit the community to continue to act on it. . . .

For years the community has sent us people with little or no mental illness, but with limited ability to compete in the world. We give these people no treatment--just three squares, a plot in the dormitory and the chance to perform desultory labors euphemistically referred to as "industrial therapy". This is all we give them. And this is all they need. But why should we give them this?

. . . .

So mental hospitals are being told to function as (a) boarding nurseries for unreconstructible Peter Pans; (b) front porches for old people; and (c) pink-and-blue ribboned panel institutions for naughty folk.

And what do we do? We ask our legislators for more wards "to relieve the overcrowding" of our mentally ill patients, for more building custodians, for more clothing and more easy chairs.

What don't we do? We don't tell the community that our function is to treat mentally ill persons and restore them to their community; it is not to provide a bin marked "Miscellaneous" to receive every personnel problem facing society.⁷

The Subcommittee finds that a central planning problem in the mental health field is that the concept "mental illness" covers multiple human circumstances and conditions but tends to produce a single solution. The term "mental illness" conveys the idea of disease, hospitals, doctors, and cures. Such thinking has contributed to the perpetuation of

⁷ William Sheeley, M.D., "Protecting State Hospital Function," Mental Hospitals, October 1959, p. 28.

service systems which tend to give the same "treatment" to masses of vastly different individuals grouped under the umbrella designation of the "mentally ill."⁸

As operating concepts, "mental illness" and "services for the mentally ill" are not sufficiently precise for legislative planning purposes. These nonspecific concepts have influenced the development of the Department of Mental Hygiene, our state hospital system, the court commitment process, and a body of laws which do not seem appropriate in the light of present knowledge. Henceforth, planning should be done in terms of specific objectives for defined groups with particular problems.

THE ISSUE OF DANGER

The basic dilemma in the commitment process stems from the wedding of treatment and custody objectives in a single system. A major reason for this fault seems to lie in equating mental illness with danger.

⁸"The whole crux of the matter is individualized treatment. We don't take a bunch of people suffering from pneumonia and paralysis, polio, and cancer and throw them all together into a big institution and treat them all alike or just keep them there as in a storage bin. We give them individual treatment, according to their individual sickness." Testimony of Albert Deutsch, Hearings Before the Subcommittee on Constitutional Rights of the Committee on the Judiciary, United States Senate, 87th Congress, First Session, 3/28-29-30/61, p. 53.

The nondescriptive term "mental illness" not only serves to group a variety of dissimilar problems into a single medical mold, but it also seems to carry a connotation of dangerousness.

For hundreds of years, people have equated mental disorders and violent behavior. It is true that some people with mental disorders may also be dangerous,⁹ but the stereotyped view is that mentally ill people are uncontrolled "raving lunatics". If this assumption were true, a finding of "mentally ill" would be equivalent to a finding of "dangerous". If this assumption were true, one could find no fault with a court system that replaces legal proof of danger with a diagnosis of "mentally ill" for the purpose of removing dangerous people from the community. If this assumption were true, one could find no fault with a

⁹ The Subcommittee's studies found that among all patients brought before the commitment court 26 percent were seen as being dangerous to themselves or others, while among all hospital residents only 13 percent were judged to behave in ways indicating danger to themselves or others. (See Appendix, Table II.)

custodial hospital system for all those labeled as "mentally ill".¹⁰

But the assumption is unproven.

After a careful comparison of commitment rates and crimes of violence in the United States, Morton Birnbaum, M.D., a noted medical and legal authority, found no evidence to support the notion that the safety of the community is enhanced by institutionalizing large numbers of mentally disordered persons who have not been proven dangerous.

. . . as the lay press frequently seems to portray the committed mentally ill as almost universally homicidally or suicidally inclined, it may be worth noting that the variations in the commitment rates of the several states do not appear to be related to variations among the states in the rates of murder and nonnegligent manslaughter and of suicide. It appears, therefore, that allowing the severely mentally ill to

¹⁰ . . . the primary function of the institution is a custodial one for the majority of the patients. (Emphasis added.) The presence of a treatment-minded staff, and of humane and enlightened administration, doubtless mitigates some of the evils of the custodial function, but does not and cannot by itself abolish the function. The point I am trying to make is that the custodial culture within the mental hospital is in large part an inevitable consequence of the expectations of the population we serve. Our society hopes for successful treatment, but it demands safe custody of those whom it rejects. The pressure for security is constant, unremitting, and a long accumulation of responses to this pressure for safe custody is embodied in hospital customs, traditions, regulations, laws, and architecture." Robert C. Hunt, M.D., "Ingredients of a Rehabilitation Program," An Approach to the Prevention of Disability from Chronic Psychoses, Proceedings of the 34th Annual Conference of the Milbank Memorial Fund, 1957, Part I, p. 15.

remain in the community or institutionalizing them has no significant effect on the rates of murder and nonnegligent manslaughter and suicide.¹¹

Still, the ancient "mad dog" stereotype of the mentally disordered seems fixed in the public's mind and the mass media tend to perpetuate these public attitudes.

Thomas J. Scheff, sociologist at the University of California, former mental health consultant to the Wisconsin State Legislature, and one of the nation's most incisive critics of the commitment court system, discusses the role of the press in perpetuating the "mad dog" stereotype:¹²

In newspapers it is a common practice to mention that a rapist or a murderer was once a mental patient. Here are several examples: Under the headline "Question Girl in Child Slaying," the story begins, "A 15-year-old girl with a history of mental illness is being questioned in connection with a kidnap-slaying of a 3-year-old boy." A similar story under the headline "Man Killed, Two Policemen Hurt in Hospital Fray," begins "A former mental patient grabbed a policeman's revolver and began shooting at 15 persons in the receiving room of City Hospital No. 2 Thursday." . . . (Emphasis added.)

. . .

Even if the coverage of these acts of violence was highly accurate, it would still give the

¹¹ Morton Birnbaum, LL.B., M.D., "Some Comments on 'The Right to Treatment,'" Archives of General Psychiatry, Vol. 13, July 1965, p. 41.

¹² Thomas J. Scheff, Being Mentally Ill: A Sociological Theory, pp. 71-72.

reader a misleading impression because negative information is seldom offset by positive reports. An item like the following is almost inconceivable:

Mrs. Ralph Jones, an ex-mental patient, was elected president of the Fairview Home and Garden Society at their meeting last Thursday.

Because of highly biased reporting, the reader is free to make the unwarranted inference that murder and rape and other acts of violence occur more frequently among former mental patients than among the population at large. Actually it has been demonstrated that the incidence of crimes of violence (or of any crime) is much lower among former mental patients than in the general population.

While the commitment law distinguishes between dangerous and nondangerous persons, the Subcommittee has found that most commitment courts do not concern themselves with this distinction, consider it a legal formality, and generally commit citizens on the sole ground of a finding of "mental illness".¹³

In the Subcommittee's one-day commitment court survey, observers reported that of those persons seen before the commitment court, only 8 percent appeared to be "dangerous to others," while 18 percent were seen to constitute, in some manner, a "danger to themselves." (Often the observers felt that confused, senile, or dependent behavior indicated

¹³ See Chapter II for detailed analysis of the court process.

danger to the self.) Thus, three-fourths of all persons involuntarily committed to a state hospital were thought to be in need of "supervision, treatment, care, or restraint." These are the "nondangerous" mentally ill.

The Subcommittee's survey of state hospital residents found that about 9 out of 10 persons who are now resident in a state hospital were classifiable as "nondangerous" persons. It appears that not only are three-fourths of all persons who are committed to the state hospital "nondangerous", but "nondangerous court committed patients are the very ones who tend to remain for long periods of time. They accumulate until they become the bulk of all state hospital patients. (84 percent of the sample of state hospital residents had been committed.)

Further, among nondangerous patients, only 2 percent receive individual or group therapy, 12 percent receive drug therapy, 1 percent receive electro-convulsive therapy--while 41 percent receive "milieu therapy" and 40 percent receive only long-term custodial care.

With more complete data now available, it is clear that the dual mental health objectives--treatment and custody--can be better achieved in two separate systems. What is required is a voluntary system for providing prompt and appropriate assistance to citizens suffering from mental

disorders without any stigma or loss of liberty; and an involuntary system for identifying and separating dangerous persons from the community, with full due process of law, and providing them with such treatment and custody as may be required.¹⁴

¹⁴" . . . it ought to be possible in this state to engineer a result that will limit the use of court proceedings to those cases that are really dangerous to themselves or to others, and in practice we might find that our proportion is comparable to that of British experience: 5 percent or less." Testimony of Judge Winslow Christian, California Senate Fact Finding Committee on Judiciary, Subcommittee on Commitment Procedures for the Mentally Ill, Admission and Care and Treatment - A Report on Commitment Procedures, January 1965, p. 40.

CHAPTER II

THE COMMITMENT PROCESS* AND LEGAL ISSUES

1. THE FIRST STEP - DETENTION

The greatest proportion of patients who went to state hospitals (62 percent in the fiscal year ending June 30, 1965) were sent through commitment courts. Other types of California hospitals also received patients from the commitment court. (See Appendix, Table III.) These committed persons usually were brought to an observation ward (in a county, private, or proprietary hospital) on a 72-hour hold,¹⁵ or a detention order pursuant to a mental illness petition,¹⁶ or on a court order from the county jail where the authorities suspected mental illness.¹⁷

Those brought in on a 72-hour hold were apprehended in public, generally by police, for suspected mental illness.

*As has been indicated, the process may vary at different points from county to county. A general description is presented in this chapter as a framework for discussing the major legal issues present to some degree in every county.

¹⁵Welfare and Institutions Code, Section 5580.

¹⁶Welfare and Institutions Code, Section 5554.

¹⁷Penal Code, Sections 4011 and 4011.6.

They were brought to the observation ward, and the staff had three days to decide whether to release them or to file a mental illness petition for commitment court hearing.^{18, 19}

Those people brought in on a detention order already had a petition of mental illness filed against them. Their spouse, doctor, or a friend went to the District Attorney or the Mental Health Counselor²⁰ and convinced whichever of the officials is

¹⁸See Appendix for a summary of existing law on juvenile, alcoholic, and narcotic addict detentions.

¹⁹The Subcommittee survey found that approximately 30 percent of all county psychiatric hospital patients are held under the 72-hour hold, while about one percent of the state and private hospital population are being held under a 72-hour hold.

²⁰Authorization for the creation of the county office of Mental Health Counselor is contained in Welfare and Institutions Code Sections 5025-5030. In counties which have established this office, the function of the counselor is to "inquire into the antecedents, character, family history, environment, and superinducing cause of the mental disorder or mental illness of every alleged mentally disordered or mentally ill person brought before the court" Welfare and Institutions, Section 5029.

responsible in the county to begin proceedings.²¹ Depending upon the local screening policy, the official filing the petition may or may not visit the home of the person alleged to be mentally ill, and interview him as well as the person seeking his commitment. In Los Angeles County, the mental health counselor does not interview the person alleged to be insane. The San Francisco County geriatric screening unit takes a different approach:

. . . Our doctors make home visits and discovered in practically every instance, . . . family feuds, neighborhood feuds, one relative wanting to get rid of another elderly relative by stating the person was dangerous and so on.²²

²¹ There is evidence to suggest that the filing of the petition virtually insures commitment and that subsequent psychiatric and judicial evaluation may be ceremonial rather than functional.

" . . . the patients who are admitted on order of detention by the court, generally 95 percent of them go on to commitment." (Emphasis added.)

(Testimony of Dr. Edward J. Stainbrook, Hearing of Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, December 20, 1965, p. 35.)

- - - -

"The interviewer is making an important judicial decision as 95 percent of the alleged deviants who are passed through this initial stage of psychiatric screening are committed by the court."
(William Austin Wilde, "Decision Criteria in a Stage of Psychiatric Screening," unpublished Master's dissertation, University of California at Santa Barbara, June 1966, p. 49.)

²² Testimony of Miss Mary Lou Clark, Hearing of Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, January 18, 1966, p. 114-15.

Once the petition is filed, a policeman, uniformed or in civilian clothes (again depending upon county policy) goes out to bring the alleged mentally ill citizen to the observation ward. Although the law²³ states that a person should not be detained pending commitment hearing unless the judge signing the order believes the person constitutes a danger to himself or others, the Department of Mental Hygiene has found that detention orders are routinely filed for all mental illness petitions in many counties.

. . . In actual practice, there is a tendency to issue an order of detention for every petition, irrespective of the Welfare and Institutions Code provisions which state that this should be done only when the individual, because of his illness, is likely to injure himself or others if he is not immediately hospitalized.²⁴

In some counties the judge takes a cautious view of the detention order:

. . . if a man doesn't object, why go through all that? Why don't you just let the man go up to the state hospital and let him volunteer? We are all proceeding upon the theory that all families love one another, but I found in my experience, there are certain members of the family who don't love one another, who wish to avoid their responsibility I have insisted that the orders of detention be cut down . . . there is another method we have devised to bring them out without having the order of detention. . . . they are served with a paper and told to come . . . first

²³Welfare and Institutions Code, Section 5554.

²⁴California Department of Mental Hygiene, Screening the Mentally Ill Before Court Commitment - A Mental Health Planning Study, December 1965, p. 16.

we have been asked to sign an order of detention and I refused and we give the alternative to let the person come in himself and there isn't one who has had a paper served to come, who has failed to show up and not one of those has been found mentally ill by the so-called medical examiner.²⁵ (Emphasis added.)

The citizen who is being detained for "observation" is generally held in the psychiatric ward of the county hospital.

Although the situation described below does not apply in every California county, it is an accurate description of a scene all too common.²⁶

Inside the locked psychiatric admitting wards, where the cracked walls are ghastly syphilitic green and fumed-oak brown, patients sit or wander aimlessly. There's nothing else for them to do. Both men's and women's wards are crowded, confusing, noisy and sad.

In the men's ward a stalwart schizophrenic patient pounds unceasingly on the grating that covers a tiny square of his locked cell door. He shouts a stream of obscenities.

BOYS

Two teen-aged boys, seated on a bed just outside the cell, glance nervously at the distorted face of the locked-up patient. They are fearful, tense. They are here for observation after attempting suicide, and now this is all a nightmare for them, a scarring experience.

Meanwhile, on an unoccupied stretch of floor in one

²⁵Testimony of Judge Joseph Karesh, Transcript of Hearing of Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, January 18, 1966, pp. 108-110.

²⁶David Perlman, "Dreary and Inhuman Crisis at S.F. General," San Francisco Chronicle, October 11, 1965. The Subcommittee Chairman (J. R. Waldie) and staff visited several observation wards including the one described.

aisle nearby a court-appointed psychiatrist and two court clerks are trying to interview a patient here for commitment.

They stand in a small knot, straining to understand the whispered testimony of the patient, trying to assure him of his legal rights in the midst of a milling, shuffling, noisy crowd of other patients.

This is, in actuality, a court of law; but it degrades the very concept of justice -- not because of human faults among these men, but because of the inhuman surroundings.

SINGLE MASS

A psychiatric assistant, tallying the patient roster in a room that serves as hydrotherapy facility, ward office, storage closet and laundry room, mourned:

"It's not just the overcrowding here: we could cope with that somehow. But it's the miserable problems that overcrowding brings; we have to throw everyone in together -- alcoholics, young schizophrenics, senile old men, addicts of all sorts.

"If only we had the physical facilities we could begin to sort them out, and start the job of helping them . . ."

The alleged mentally ill citizen on the observation ward may be denied the right to make phone calls and his letters may be censored. He may also be dressed in hospital pajamas and robe.²⁷ In this atmosphere, frequently after a weekend of anxious and isolated waiting, the person is examined. For persons against whom a petition has been filed, the observation ward exists mainly as the antechamber for the commitment court. In most

²⁷Testimony of Judge Joseph Karesh, Hearing of Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, January 18, 1966, p. 54.

counties there is little emphasis on treatment during this period of waiting.

" . . . Oftentimes with present procedures, and this does not apply to commitment procedures, but even procedures of application, screening, eligibility, etc. . . . by the time the patient has reached the far harbor of treatment they are already chronic."²⁸

Such patient care practices are not only contrary to modern theories of psychiatric crisis intervention, but they are antithetical to the treatment functions of a hospital.

2. THE SECOND STEP - DIAGNOSIS²⁹

A. THE QUALIFICATIONS OF MEDICAL EXAMINERS

The medical examiners employed to diagnose and make recommendations to the court are not required to be psychiatrists. They may be drawn from a panel of local physicians, staff doctors from a mental hospital, private psychiatrists or any combination of these and others, including retired general practitioners. What is necessary is that they both be medical doctors,³⁰ that each one independently examines the person alleged to be ill,³¹

²⁸Testimony of Dr. J. M. Stubblebine, Hearing of Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, January 18, 1966, p. 18

²⁹See also Chapter 5 for more detailed discussion of the reliability of psychiatric diagnosis and predictions.

³⁰Welfare and Institutions Code, Section 5000.

³¹Welfare and Institutions Code, Section 5559.

and that they appear as witnesses at the commitment hearing.³²

B. IN SOME COUNTIES THE EXAMINATION IS MADE UNDER VERY TRYING CONDITIONS

CHAIRMAN WALDIE: . . . I saw the men's ward . . . about 60 patients in the ward.

DR. POLIAK: Yes, all the examinations are conducted in the ward. We usually try to . . .

CHAIRMAN WALDIE: With the patient seated on a bed and you are seated on the other bed across from him?

DR. POLIAK: As much as possible we try to take the patient into an empty room and get the examination there.

CHAIRMAN WALDIE: That was not happening this morning. Did I just happen to walk into a morning when it was unusual?

DR. POLIAK: It doesn't always happen. I know I, at least, try to have some privacy.

CHAIRMAN WALDIE: I didn't see many opportunities for privacy on that ward.

DR. POLIAK: There are not many, that is true.

CHAIRMAN WALDIE: It would clearly be a desirable thing, would it not, to hold an examination were there to be privacy?

DR. POLIAK: It would very much, yes.

CHAIRMAN WALDIE: The examination I saw conducted -- there were three or four patients listening in and watching and observing the one being examined.³³

³²Welfare and Institutions Code, Section 5564

³³Transcript of Hearing of Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, January 18, 1966, p. 32.

C. THE EXAMINATION IS OFTEN MADE VERY RAPIDLY

"CHAIRMAN WALDIE: How long does an examination normally take?"

MEDICAL EXAMINER: "It varies a great deal. In some instances, it may take five minutes. In some instances, we do two or three examinations. It may involve an hour or two. I'd say the average was just ten or fifteen minutes."³⁴

- - - -

"CHAIRMAN WALDIE: . . . Can you tell me this, how long do the doctors look at these fellows?"

PUBLIC DEFENDER: "About a five-minute examination on the average."³⁵

In a study of conditions in one of California's county observation wards, Karl W. Kreplin reports:

The court examiners . . . handle approximately ten cases each court day on the average The psychiatrist from one of the pairs told me:

"Dr. X and myself like to examine the patient individually; then we get together and look at the chart. We make a decision by compiling these different views. We usually don't like to look at the chart until after we have seen the patient ourselves. ('Chart' refers to the ward record of the patient)."

However, this ideal is usually not put into practice by this pair of examiners. What usually happens, especially on busy mornings, is that the examiners are handed a large number of petitions. They divide the petitions among themselves and proceed to copy from the chart most of the

³⁴Hearing of Assembly Interim Committee on Ways and Means, January 18, 1966, p. 32.

³⁵Hearing of Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, December 20, 1965, p. 71.

relevant information. After copying the information they go up to the wards to see the patient. The examiner who is handling any one case will examine a patient's "mental status" much in the same way as the ward resident does. The average interview is probably about four or five minutes. The examiner may fill in additional information required while interviewing the patient. He does not have to make a diagnosis, but only decides whether or not the person should be committed. After the one examiner has interviewed the patient, the other examiner comes by at a later time and will talk with the person briefly. After interviewing patients, both examiners return to the courtroom and finish off the details of the petitions (filling in any relevant information, signing them, etc.). At this time there may be some brief discussion about particular cases.³⁶ (Emphasis added.)

The speed of examinations seems to lend credence to the belief of some critics of the commitment system that a presumption of insanity permeates the process.

In a critical analysis of commitment proceedings in Illinois, Luis Kutner observes:

As might be expected, the examination by the state physicians is given great, if not decisive, weight at the court hearing. The flaw is that the so-called "examinations" are made on an assembly-line basis, often being completed in two or three minutes, and never taking more than ten minutes. Although psychiatrists agree that it is practically impossible to determine a person's sanity on the basis of such a short and hurried interview, doctors at the Mental Health Clinic recommend confinement in 77 percent of the cases. It appears that in practice the allegedly-mentally-ill is presumed to be insane and bears the burden of proving his sanity in the few minutes

³⁶Karl W. Kreplin, "Mental Illness Commitment: A Study of the Decision-Making Process," (unpublished dissertation, University of California at Berkeley, January 1966, pp. 50-51.)

allotted him.³⁷

Thomas J. Scheff found the same conditions in Wisconsin:

The interviews ranged in length from five minutes to 17 minutes, with the mean time being 10.2 minutes. Most of the interviews were hurried, with the questions of the examiners coming so rapidly that the examiner often interrupted the patient, or one examiner interrupted the other. All of the examiners seemed quite hurried. One psychiatrist, after stating in an interview (before we observed his examination) that he usually took about thirty minutes, stated:

"It's not remunerative. I'm taking a hell of a cut. I can't spend 45 minutes with a patient. I don't have the time, it doesn't pay."

In the examinations that we observed, this physician actually spent 8, 10, 5, 8, 8, 7, 17, and 11 minutes with the patients, or an average of 9.2 minutes.

In these short time periods, it is virtually impossible for the examiner to extend his investigation beyond the standard orientation questions, and a short discussion of the circumstances which brought the patient to the hospital.³⁸

It is sometimes reasoned that the length of time involved in the court examiner's diagnostic evaluation is not critically important because the staff on the observation ward has had

³⁷Luis Kutner, "The Illusion of Due Process in Commitment Proceedings," Northwestern University Law Review, Vol. 57, pp. 383-399.

³⁸Thomas J. Scheff, "The Societal Reaction to Deviance: Ascriptive Elements in the Psychiatric Screening of Mental Patients in a Midwestern State," Social Problems, Spring 1964, Vol. II, No. 4, p. 408.

opportunities to observe the patient for several days and that these observations may compensate for the brief examination by the court's medical examiner. However, it is also possible that conditions on the observation ward and a pervading presumption of insanity tend to reduce drastically the reliability of the diagnostic activities during the detention period.

Karl W. Kreplin describes the diagnostic activities during the observation period in a large county hospital in California:

. . . the patient's condition on the ward, including his mental state and behavior, is of prime importance in his diagnosis. Some of the pathologies seen by the Resident might be seen in a different light. Many of the patients are seen as having a "flat affect". This usually means that when the patient was interviewed by the Resident he showed no emotion about the topic being discussed (perhaps some incident in the patient's life), or else responded in a very low voice. This is a crucial symptom since it may indicate schizophrenia. The fact that is often overlooked is that the beds on the ward are six inches apart; patients in adjoining beds can easily overhear the conversation if the patient speaks in normal tones. It is possible that many patients are self-conscious about discussing their problems in front of other patients.

The majority of the patients are brought to the ward by the police. They are being held against their own will. They have not entered into the patient role voluntarily. The Resident automatically assumes the patient-doctor role-relationship, since the setting is the hospital. Some of the patients may consider the Resident's questions about them to be "none of

his business." The patient may not give a concise account of the reasons he was admitted or any of his past history because he feels no obligation to do so. Patients who give an imprecise account of their history are called "vague", "lacking insight", or "lacking judgment". Being vague and lacking judgment are also symptoms of schizophrenia . . .

The staff generally overlook the possible explanations as to why a patient does not socialize with other patients. We can imagine many reasons to explain this but the staff sees it in only one way: the patient does not socialize with others because he is schizophrenic.

In assessing the patient's behavior in the outside world, the staff generally ignore the variable possibilities for why people behave the way they do. For example, if a patient has a poor work history, it is usually assumed that the reason for his poor history is that he is unable to function on the job because he is disturbed. The other possible reasons that people do not work are ignored (unavailability of jobs, a person's distaste for work in general, etc.). If a patient holds a more menial job after he has held a "higher level" job, he has "deteriorated" (for example, a change from cook to busboy). The circumstantial factors are generally ignored. If a person is always "on the move" and frequently travels about the country, it is seen as symptomatic of a possible illness."³⁹

D. THE POSSIBILITY OF A "MIDDLE CLASS BIAS" MAY AFFECT THE RELIABILITY OF DIAGNOSIS

The majority of people passing through a commitment court have two things in common; they are poor and they often need a

³⁹Karl W. Kreplin, op. cit., pp. 38-39.

variety of services.⁴⁰

CHAIRMAN WALDIE: Have you ever seen a wealthy man in an involuntary commitment proceeding?

DR. STUBBLEBINE: Yes.

CHAIRMAN WALDIE: Not very often though, have you?

DR. STUBBLEBINE: No, it is true, it does happen last.

CHAIRMAN WALDIE: About 98 percent of the time they are not wealthy are they? Don't most wealthy people who have this problem seek treatment for their problem other than state hospitals?

DR. STUBBLEBINE: Yes, that is true.⁴¹

Reputable studies have concluded that "the middle-class prototype and the mentally healthy prototype are in many respects equivalent."⁴²

A study on an observation ward in California concludes that the evaluation of "mental Health" is based heavily on

⁴⁰"Any community mental health program is likely to become a poverty program, enmeshed in the problems of economic deprivation, unemployment or unemployability, and social disorganization."* Henry Weihofen, "Mental Health Services for the Poor," California Law Review - Symposium: Law of the Poor, May 1966, Vol. 54, #2, University of California, p. 922.

*Pasamanick, Scarpitti, Lefton, Dinitz, Wernert & McPheeters, Home vs Hospital Care for Schizophrenics, 187 A.M.A.J. 177, 179 (1964).

⁴¹Testimony of Dr. J. M. Stubblebine, Hearing of Assembly Interim Committee on Ways and Means, January 18, 1966, p. 25.

⁴²Orville R. Gursslin, Raymond G. Hunt, and Jack L. Roach, "Social Class and the Mental Health Movement," Mental Health of the Poor - New Treatment Approaches for Low Income People, The Free Press of Glencoe, 1964, p. 63.

middle class criteria.⁴³

It was found that the observation ward staff uses an implicit middle-class model of the normal healthy person against which alleged mentally ill persons are measured for signs of unhealthiness. The characteristics of this middle-class model are described as follows:

1. Self-control. The normal person can control his impulses
2. Planned life. The normal person "plans ahead"
3. Socially useful and productive. The normal person works at a job or occupation
4. Ability to deal with society. The normal person has the abilities to deal with the different problems that may arise in pursuit of some goal
5. Relates well to other persons. The normal person gets along well with other people
6. Good presentation. The healthy, normal person presents himself well to others in interaction
7. Controlled expression of emotions. The normal person shows just the right amount of emotion which is appropriate to the situation
8. Good family relations. The normal person gets along well with his spouse⁴⁴

If standards such as these are applied, poor people would seem to stand a greater chance of being committed. Middle-class standards may not be consistent with the behavior and

⁴³Kreplin, op. cit., p. 53.

⁴⁴Ibid., pp. 37-38.

condition of many poor people. In a study of rehospitalized mental patients prepared for the Department of Mental Hygiene, Miller⁴⁵ concluded that the Cornell Medical Index (CMI) psychiatric test frequently used for determining mental illness may be biased toward these lowest social classes:

For example, among the items are: "Do you get frequent spells of complete exhaustion or fatigue?" Do you often have small accidents or injuries?" Such items may well reflect the complaints of a hard-working laborer, and may not be at all related to a "psychiatric state".

In another study of wives of working men, the authors state that:

These women regarded themselves as acted upon rather than acting. They saw the world as unchangeable. Such a woman responds only when she is approached in terms that are specific, clearly defined, and readily understood. She feels helpless in the face of a chaotic world -- she does not reach out to it. Seeing what happens in life as based on luck or fate rather than on her own actions, she has a fairly pervasive anxiety over possible fundamental deprivations. Such a woman does not lack hope, for luck may also be good, but she does not expect herself to be personally successful against forces she cannot control. Her gratifications tend to come from her own limited world of husband and children. She likes to be "needed". Yet, again, she does not see herself as having effective power over her husband, and little over her children after their babyhood. She greatly fears loneliness.⁴⁶

⁴⁵Dorothy Miller, "Mental Patient Rehospitalization: Triumph or Disaster?" California Department of Mental Hygiene, Social Research Laboratory, March 1966, p. 18.

⁴⁶Rainwater, Lee, R. P. Coleman, G. Handel, Workingman's Wife: Her Personality, World and Life Style, Oceans Publications, New York, 1959.

Compare this description of working men's wives' style with items from the CMI scale which indicate mental illness: "Do strange people or places make you afraid?" -- "Do you let worrying continually get you down?" -- "Do you usually seem unhappy and depressed?", etc.

The result of this apparent bias may be that when the salaried middle-class citizen is disturbed, he is having a "nervous breakdown". He takes a vacation, or goes to a psychiatrist or a private sanitarium. When the poor have similar symptoms, they may be found "mentally ill" and go to the county psychiatric ward and then to the state hospital.

The Subcommittee's One Day Survey of socio-economic characteristics of psychiatric patients found that many facilities could not even furnish information on such factors as family income. Where income was known, however, 59 percent of the state hospital patients, 69 percent of the V. A. patients, 50 percent of the county hospital patients, 65 percent in the private or proprietary hospitals and 91 percent of the convalescent hospital patients had a family income at time of admission below the poverty line of \$3,000 per year.

It is difficult to believe that the commitment system would operate if citizens processed through it were not the

poorest in our society.⁴⁷

3. THE THIRD STEP - RECOMMENDATIONS TO THE COURT

A. VAGUE CRITERIA FOR COMMITMENT

Under Section 5550 of the Welfare and Institutions Code, a medical examiner may recommend citizens for commitment to a state mental hospital if he finds that they are in such mental condition that they are, (A) "in need of supervision, treatment, care or restraint," or (B) "dangerous to themselves or to the person or property of others, and are in need of supervision, treatment, care or restraint."

The Subcommittee has found that many doctors and judges have great difficulty working with these two vague criteria:

"CHAIRMAN WALDIE: . . . But there is a Subsection A and a Subsection B. Are you aware of the statute?"

MEDICAL EXAMINER: "Yes, I am."

"CHAIRMAN WALDIE: Now on no petition that I examined, and I have two here and I have examined others this

⁴⁷As the Director of California's State Department of Mental Hygiene has testified, the vast majority of state hospital residents are poor people unable to pay for services: "In 1965 there were some 27,000 patients admitted both for hospitalization and observation and 1,458 or 5 percent paid the full cost of their hospital care. That is either they paid it or their spouse paid it or there was some insurance scheme that paid it. Then there were those 9,685 or 35 percent more or less who paid for a week or two weeks . . ." (Testimony of Dr. James V. Lowry) Transcript of Hearing of Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, December 20, 1965, p. 51.

morning and on no order of commitment either, I might say, or judgment of mental illness and orders for care, did I see either A or B marked"

MEDICAL EXAMINER: "Well, one or the other reports are assumed in every recommendation that is made for them."

"CHAIRMAN WALDIE: Why are they assumed? Are they not found?"

MEDICAL EXAMINER: "They are found mentally ill and just a legal provision there that they must be so mentally ill that they require supervision care treatment or considered a danger to themselves."

"CHAIRMAN WALDIE: . . . It should be more closely defined if he was only in need of treatment or care that he perhaps should not be involuntarily committed any more than the man who is in need of treatment or care for his foot or for his arm should be involuntarily committed for that I don't think it is an optional matter and I am curious as to why no petition alleges which one of these sections under which he is mentally ill"

MEDICAL EXAMINER: "Well, it just simply requires A or B. You are required to say whether it is A or B."

"CHAIRMAN WALDIE: Reading from the certificate of the medical examiners/ It does, Doctor, it says 'the petitioner believes a person so mentally ill (A) as to be in need of supervision care or treatment and/or (B) as to render said person dangerous to himself or the person or property of others.' Strike out A or B, whichever is not applicable." (Emphasis added.)

MEDICAL EXAMINER: "Well, it's impossible to say whether B is applicable or not in many cases."

"CHAIRMAN WALDIE: If B is not applicable, if he's not dangerous to himself, to his own person or to the property of others, should he be committed?"

MEDICAL EXAMINER: "Well, he may still need hospital care."

"CHAIRMAN WALDIE: Well, does a man that has a sore finger that doesn't get treatment, does he, would you say that he should be involuntarily committed to the hospital to get treated?"

MEDICAL EXAMINER: "No, of course not, but"

"CHAIRMAN WALDIE: But he's not a danger to himself or to anybody's property. Should he be treated if he doesn't want it?"

MEDICAL EXAMINER: "Yes, if he is in need of treatment."⁴⁸

- - - -

"JUDGE KARESH: . . . I am of the opinion, if I may express it, that Section A is so vague that one does not actually know what it means when you say 'so mentally ill as to require custody and supervision.' I just don't know what that means And I'm frank to say that the result of the vagueness of 'A', that as a judge for many, many months, I went along with the system just because commitment was recommended and without asking any questions, I committed. In other words, I was proceeding on the theory . . . Since they were there, they were presumed to be mentally ill."⁴⁹

B. THE PRESUMPTION OF MENTAL ILLNESS AND THE TENDENCY TO RECOMMEND COMMITMENT

In one California county, Miller studied 58 commitment hearings and found that:

The medical doctors recommend commitment to the mental hospital in nearly all cases. In those few cases where they do not, they find the accused to be "emotionally disturbed" and in need of out-patient psychiatric care. Thus, not one of the 58 accused persons are given a clean bill of mental health by the examining professionals! Their examinations of the accused occurred prior to the hearing itself and, in several instances, the accused, in defending himself, announces that the doctors had not really talked with him, or had done so for only a moment, etc.⁵⁰

⁴⁸Transcript of Hearing of Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, January 18, 1966, pp. 33-35.

⁴⁹Ibid., pp. 53-54.

⁵⁰Dorothy Miller, Extracts from "County Lunacy Commission Hearings: Some Observations of Commitments to a State Mental Hospital," p. 6.

In the Subcommittee's study of commitment courts, it was found that in the month of August, 1966 (the month preceding the observation survey), out of the 1608 persons brought before the commitment court, 1217 or 76 percent of the total were actually committed. But the following month, when the data was collected by observers from the California Mental Health Association, who were physically present at the actual commitment hearings, it was found that only 43 percent of the persons brought before the court were committed, and an additional 25 percent of the persons had their cases continued. Such a difference may indicate that the presence of an interested observer suggested community alternatives or concern about the commitment process.

The fact that the patient is involved in the commitment process in the first place appears to weigh heavily against the possibility of a judgment of sanity. Even in "borderline" cases or where there is a lack of evidence there may be a tendency to recommend commitment. Scheff describes the phenomenon:

. . . . Thus, one examiner, employed by court A stated that he had recommended 30-day observation for a patient whom he had thought not to be mentally ill, on the grounds that the patient, a young man, could not get along with his parents, and "might get into trouble." This examiner went on to say:

"We always take the conservative side. /Commitment or observation/ Suppose a patient should commit suicide. We always make the conservative decision. I had rather play it safe. There's no harm in doing it that way."

The language used by these physicians tends to intimate that mental illness was found, even when reporting the opposite. Thus in one case the recommendation stated: "No gross evidence of delusions or hallucinations." This statement is misleading, since not only was there no gross evidence, there was not any evidence, not even the slightest suggestion of delusions or hallucinations, brought out by the interview.

These remarks suggest that the examiners prejudge the cases they examine. Several further comments indicate prejudgment. One physician stated that he thought that most crimes of violence were committed by patients released too early from mental hospitals. (This is an erroneous belief.) He went on to say that he thought that all mental patients should be kept in the hospital at least three months, indicating prejudgment concerning his examinations. Another physician, after a very short interview (8 minutes), told the observer:

"On the schizophrenics, I don't bother asking them more questions when I can see they're schizophrenic because I know what they are going to say."

Another physician, finally, contrasted cases in which the patient's family or others initiated hospitalization ("petition cases," the great majority of cases) with those cases initiated by the court:

"The petition cases are pretty automatic. If the patient's own family wants to get rid of him you know there is something wrong."⁵¹ (Emphasis added.)

In the Subcommittee's Survey of Commitment Courts, observers reported that in 78 percent of the cases, the examining physicians recommended commitment. In only 11 percent of the hearings were alternatives even discussed by

⁵¹Scheff, Social Problems, pp. 409-411.

the examining physicians. In contrast, the observers administering the Subcommittee's questionnaire stated a belief that alternatives to commitment would have been desirable in 47 percent of the cases. (In three out of four of these committed cases, the observers suggested out-patient services as the alternative.)

4. THE FOURTH STEP - THE COMMITMENT COURT

The Subcommittee's survey of California's commitment courts found that the average length of commitment hearings in this state was 4.7 minutes. (One third of them took less than two minutes each!)

Here the process of admission to a mental hospital takes on somber reality: in the corridor outside, the patients who have requested a hearing, dressed in pajamas and hospital bathrobes, wait in a straggly gray line to present their protests against being "sent away." A psychiatrist reads to the judge the physician's report setting out the initial observation and recommendations on the need for care. Most patients, when called into the courtroom talk up in their "defense"; their stories are sometimes rambling and incoherent, sometimes only a pitiful plea to go home. There is no regular representation of the patient's rights; many observers point out that the hearing may not meet minimum constitutional requirements. The judges can and do try to explore the patient's side of the case, but often they must make a decision on the grave issue of personal liberty with little more than scanty evidence.⁵²

The treatment vs. civil liberties dilemma is clearly

⁵²New York Special Committee to Study Commitment Procedures, Mental Illness and Due Process, p. 7.

dramatized in the courtroom. Presumably the purpose of the court proceeding is to safeguard the citizen from a diagnostic error so that no sane person will ever be committed. This places the judge in the position of attempting to evaluate the validity of the doctor's recommendations. Some judges are not comfortable with this assignment and almost always accept the medical evaluation:

JUDGE REPPY: ". . . We are guided almost 100 percent by what the medical examiners testify to. I find my role with respect to that it is mostly relegated to a discussion with the medical examiners as to various possibilities that might be available for the patient that they consider to be mentally ill.

"I hardly conceive of myself, as putting myself up as a better medical expert than the examiners and saying 'You think this man is mentally ill but I don't.'"⁵³

Other judges disagree.

Judge Karesh at the San Francisco County commitment court feels that the court can and should play an active role.

I am of the opinion that the public defender should have a right to ask the court on a proper showing for the appointment of an independent medical examiner, so that the court could decide whether or not the person should or should not be committed to the state hospital.

Now in criminal cases, they do this. Why not in this kind of case? Why are we so lax in mental illness commitment proceedings? Perhaps it all

⁵³Senate Fact Finding Committee on Judiciary, Admission Care and Treatment, January 1965, p. 13

goes back to the idea that, "Well, we would do it for their best interests and protection."

What about those people for whom we appointed counsel? Time and time again it happened. I can document it. We appointed counsel and counsel was able and vigorous. My medical examiners, after that kind of representation change their minds. We need the public defender and I want the public defender to be able to come in and say, "Judge, I want an independent medical examiner." And if the man can't afford it, appoint it at the cost of the State. I think that would be a very fine thing. (Emphasis added.)

. . .

. . . And I dislike the use of such words as hallucinations or delusions or delusional dementia or paranoia or schizophrenia, without telling me what particular facts there are that causes the recommendation. Without it, gentlemen, we're operating completely in the dark.

They talk about voices. They hear voices. Well, the question is what do the voices tell them to do? They will answer and say, "Well, maybe the voices don't tell them to do anything wrong for now. But maybe in the future they might tell them to do something wrong." I can't go along with that philosophy. . .⁵⁴ (Emphasis added.)

Some lawyers point out that since the court hearing is often a sham, it should be eliminated because it not only fails to accomplish the legal objective but they believe it interferes with treatment objectives:

. . . The intention of these Commitment statutes is to provide an independent determination by an impartial body of the need for hospitalization before

⁵⁴ Transcript of Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, January 18, 1966, p. 63.

admission. In actual practice, however, the court-ordered admission provides what one writer has called "the illusion of due process." . . . Court orders in many cases, therefore, are nothing more than a rubber stamp of the recommendation of the two examining doctors. The entire court procedure usually delays the institution of treatment and is a painful, traumatic experience for the patient and his family at a critical time in his illness. Thus, the court-ordered admission not only fails to do what it was intended to do -- to provide an independent determination of the propriety of admission; but it does what it ought not to do -- delays treatment, causes trauma to the patient, and adds to the stigma of hospitalization.⁵⁵

But other lawyers argue against this point of view:

. . . this argument, however valid it may appear medically, is based on the presumption that all persons who are the subject of commitment proceedings are in fact insane. Once this presumption is replaced by the more reasonable presumption that some perfectly sane members of society will be caught up in the commitment machinery, the argument collapses. It is precisely to determine which of the persons alleged to be insane are in fact insane and need to be committed that is the purpose and function of the commitment process. Indeed, one presumes his conclusion when he argues, as some doctors do, that a commitment process should be operated on the theory that all persons threatened with confinement are in fact insane, and need to be "protected" from the unpleasant experience of a court hearing.⁵⁶ (Emphasis added.)

The peculiar blending of medical and legal objectives in the court also produces different views regarding the

⁵⁵Ruth Roemer, "Compulsory Hospitalization of the Mentally Ill: Balancing the interests in Liberty and Health," p. 2. Paper presented at seminar on Court Commitment of the Mentally Ill, Metropolitan State Hospital, 25 June 1966.

⁵⁶Kutner, op. cit., p. 396.

role of defense attorneys in the commitment courts.

A private counsel who had represented 15 persons in commitment court testified that the presumption of mental illness in the process bothered him very much and that, ". . . I take my position to be that it is an adversary proceeding and I will do everything in my power to try and bring out my client's position in the case."⁵⁷ But it appears that many defense attorneys do not view the commitment process as an adversary proceeding. In the Subcommittee's observational study of California commitment procedures, it was found that 30 percent of the patients were represented by counsel, but only four attorneys objected or contested the person's commitment.

A public defender in the Los Angeles commitment court takes this view:

MR. SMITH: When I am assigned to defend a criminal defendant, no. We have very clear criteria in that sort of thing. (Emphasis added.)

CHAIRMAN WALDIE: What are they?

MR. SMITH: That the duty of defense counsel is to assert every legal defense. (Emphasis added.)

CHAIRMAN WALDIE: And what is the duty of the defense counsel of the fellow that is being accused of being a threat to the community and to himself?

⁵⁷Testimony of Harry Lohstroh, Transcript of Hearing of Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, January 18, 1966, p. 81.

MR. SMITH: I may have a duty to assert every legal defense. I have never quite been able to go that far myself.⁵⁸ (Emphasis added.)

Judges who may wish to introduce additional elements of due process in the commitment court are hampered by lack of counsel in their efforts to explore all facets of the mental illness petition. For example, in the Los Angeles commitment court there are one and two-thirds public defenders to represent between 90 and 120 clients each week.

Public defenders who practice in the commitment court are often helpless:

MR. ROBERT NICCO: . . . we feel we are just giving token representation at the present time. We are called; we go up there; we're there. We can do some good but not the job we think we should be doing. We feel we should be representing the patient in the same manner as private counsel would and a private counsel would certainly try to develop alternatives, keep him out of the state institution if possible. We have been unable to do this at the commitment proceedings.⁵⁹

In general, the court fails to function as a court should, and most cases are processed kindly but rapidly. The official legal order bringing the citizen to the court begins: "The

⁵⁸Transcript of Hearing of Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, December 20, 1965, p. 61.

⁵⁹Transcript of Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, January 18, 1966, pp. 45-46.

people for the best interest and protection of John Doe, as a mentally ill person":⁶⁰ These words manifest predetermination as well as benevolence. The following description is fairly typical of the process:

The actual setting of these hearings was a small auditorium, where the principles sat around a long table. Present at the table were the judge, two doctors, the sheriff in full uniform complete with a gun.* On one end was the clerk of the court, who swore in all witnesses (but not the accused). A county court reporter was added after two observed hearings. The judge introduces himself and the doctors in a very stylized manner to each patient as he comes before the commission, but he does not state to the accused the purpose of the hearing. The hearing proceeds very rapidly, beginning with a brief report over the accused's situation, given by one or both of the examining medical doctors.⁶¹ (Emphasis added.)

One can only wonder what the court experience meant to more than 13,000 Californians committed last year. If the purposes of the system are so confusing to the judges, doctors and lawyers who practice in it, the citizens who come before the court for three or four minutes must be completely bewildered. Many must believe that they are being incarcerated for terrible deeds.

⁶⁰Justice Brandeis warned, "Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent." Olmstead v. United States, 277 U.W. 438, 479 (1928) (dissenting opinion).

⁶¹Dorothy Miller, op. cit., Social Problems, pp. 4-5.

*Two non-English speaking Mexican accused patients who were committed thought they were being confined in a military prison and cited this uniformed officer as partial empirical evidence for this definition of the situation.

Current practice is too much like the procedure for handling criminals from which it evolved. The English Law of 1744 said:

" . . . It shall and may be lawful for any two or more justices of the peace to cause such a person (who by lunacy or otherwise is furiously mad) to be apprehended and kept safely locked up in a secure place and, if such justices shall find it necessary, to be there chained . . ."

Today, the patient who goes through a court procedure, is committed and transported in restraints to a hospital usually by armed guards and is being treated very similarly to the patients of two hundred years ago.⁶²

Not only does the commitment process violate treatment objectives, but it is clear that it also fails to satisfy the objectives of sound legal process. From this standpoint, it is not even as good as the practice in criminal courts.

Judge Joseph Karesh* suggests one way out of the dilemma:

I think the criterion should really be, a danger to himself or to others, and that in all other particulars they ought to be permitted to volunteer, if the hospital wants them. But, no one should be committed to a state hospital, in my humble judgment, unless he is dangerous to himself or to others.⁶³ (Emphasis added.)

⁶²Testimony of Dr. James Lowry, Transcript of Hearing of Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, December 20, 1965, p. 44.

⁶³Testimony of Judge Joseph Karesh, Transcript of Hearing of Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, January 18, 1966, p. 53.

*For his outstanding leadership in improving the commitment process in San Francisco, Judge Karesh received the 1965 "California Annual Mental Health - Retardation Award for Exceptional Services."

5. LEGAL DISABILITIES AND STIGMA RESULT FROM COMMITMENT

Except for those who are dangerous and may require custody, other persons are sent to state hospitals because they "need treatment". The hope is, through treatment, to restore them to health and a place in society. As discussed in Chapter III, there is evidence of inadequate treatment in state hospitals. There is also evidence that serious legal disabilities and stigma are related to commitment. In this light, it may be quite realistic for many citizens to object to being committed -- even though they may require a variety of services.

DR. EDWARD J. STAINBROOK: . . . Most of these psychiatric patients I know are quite willing to accept themselves as being disturbed, but they have great reservations about being a patient our way, and this acceptance of what being a patient is going to mean for them, being put away in a hospital and not coming back.⁶⁴ (Emphasis added.)

A. LEGAL DISABILITIES

Upon being committed to a California state hospital, a citizen automatically loses any public office he may hold and the right to own or possess firearms, to engage in various businesses and professions, or (after six months) the right to vote. The commitment is grounds for deprivation of numerous other rights⁶⁵

⁶⁴Senate Fact Finding Committee on Judiciary, Admission Care and Treatment, January 1965, p. 36.

⁶⁵See Appendix for listing of all legal disabilities.

among which are the right to obtain a marriage or driver's license, to convey property or to procreate children.

By contrast, the citizen who voluntarily seeks help in a mental institution incurs only six of these liabilities. For the individual seeking help, however, even these six, or any of them, can be very important and may easily keep the person from seeking help when he needs it most. For instance, even the voluntary seeking of help can result in suspension of the license to practice many professions and occupations.⁶⁶

But it is the involuntary, court-committed patient, who is most crippled by the legal impact of his hospitalization. He suffers a potential sixteen disabilities. (Seven more than those imposed on a convicted felon.)⁶⁷

The existence of disabilities such as these undoubtedly discourages many people from seeking hospitalization. There may be no good medical reason to impose most of these disabilities:

⁶⁶" . . . it would seem to me that I can't think of anything that would be more conducive to preventing a licensed person in the State of California from seeking assistance that he might very well need . . ." Chairman Waldie at Subcommittee Hearing, January 18, 1966, p. 5.

⁶⁷See Appendix for comparison of legal disabilities imposed on committed mental patients and felons.

It must be clearly understood that the establishment of a mental illness does not, ipso facto, warrant a finding of incompetency. Throughout the legal history of mental illness there has been considerable confusion about the two concepts, and in many states commitment can act as a automatic determination of incompetency. From a medical point of view there is not, necessarily, any connection between the two, and in general, psychiatrists are much concerned that any mental patient within a hospital should exercise as many of his ordinary civil rights as he has the capacity to exercise, such capacity being determined by medical judgment. We have in mind such rights as signing checks, selling property, retaining an automobile license, making purchases, executing contracts, voting, making a will and the like. He must also retain the right to communicate by sealed mail, to receive visitors, to the confidentiality of his case records, to habeas corpus, and the right to protest further hospitalization.

In general, all laws governing mental illness should recognize that many hospital patients are perfectly capable of handling their own affairs and that any automatic tieup of incompetency and commitment is harmful.⁶⁸ (Emphasis added.)

The most serious legal disability of all is loss of liberty. This disability is nowhere mentioned in the statutes because it is implicit in the commitment process; and the commitment process is based on an assumption that the only way to get people to accept treatment of their mental illness is to hospitalize them against their will.

It must not be assumed that people have no objection to being committed for treatment. In the Subcommittee's study of the commitment courts, observers reported that 27 percent

⁶⁸Testimony of Dr. Francis J. Braceland, U. S. Senate Hearings before the Subcommittee on Constitutional Rights of the Committee on the Judiciary, 87th Congress, 1st Session, p. 82.

of the persons objected to their commitment, often by weeping or by begging not to be sent away.

B. QUASI-LEGAL DISABILITIES

From the time the police arrive at the door with a detention order until discharge from the state hospital, the mentally disordered citizen is subject to rules and administrative procedures which sharply limit his usual rights as a citizen.

Pickups on detention orders are often made at night to insure that the person is home, and there may be little effort to inform the person of his legal rights.

MR. LOHSTROH: . . . In the code it provides . . . that the person who is subject to a petition be warned of his legal rights -- his rights to obtain counsel, etc. Now I notice on our forms on Contra Costa County that unless the sheriff or whoever picks him up advises him orally, the only notice he has is a small printed section on the back of the petition which is titled "Notice WI 5050.5." I submit this would be a very difficult thing for someone who is picked up at two o'clock in the morning to find, for one thing.⁶⁹

Persons on observation wards are often held there against their will, and denied the right to correspond or make phone calls. Meanwhile, the unverified petition which

⁶⁹Transcript of Hearing of Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, January 18, 1966, p. 85.

contains allegations that may be groundless or untrue,
is a matter of public record.

JUDGE JOSEPH KARESH: . . . In the city hall you'll find terrible things, like molesting a stepchild, or a homosexual. Terrible things completely unsubstantiated, completely uncorroborated, a matter of public record to thwart that person the rest of his life.⁷⁰ (Emphasis added.)

The hurried atmosphere and questionable due process of the commitment hearing, which have already been described, may be followed by a further deprivation of rights of the citizen inside the hospital. The Committee for the Advancement of Psychiatry and the Law has considered this problem in the following recommendations:⁷¹

All psychiatric patients hospitalized in either public or private institutions should retain the following fundamental rights:

1. The right of communication with persons outside the hospital.
2. The right of visitation by appropriate persons.
3. All civil and political rights guaranteed by law unless specifically revoked by individual incompetency proceedings.

⁷⁰ Ibid., p. 60.

⁷¹ Group for the Advancement of Psychiatry, Laws Governing Hospitalization of the Mentally Ill. Report submitted by the Committee on Psychiatry and the Law. VI, No. 61, May 1966, pp. 145-157.

4. The right to good medical and psychiatric treatment.^{72, 73}
5. The right to periodic review of status.
6. The right to discharge as soon as medically advisable.

The Midpeninsula Chapter of the Northern California American Civil Liberties Union in their study of "The Civil Liberties of Mental Patients" suggests that a statement of patient rights be posted in all state and private facilities for the treatment of mental illness.

C. STIGMA

Stigma is the sentence imposed on those judged unworthy by their peers. It is a bitter sentence because it guarantees a pattern of failure. Just as success breeds success so

⁷²If the right to treatment were to be recognized, our substantive constitutional law would then include the concepts that if a person is involuntarily institutionalized in a mental institution because he is sufficiently mentally ill to require institutionalization for care and treatment, he needs, and is entitled to, adequate medical treatment; that being mentally ill is not a crime; that an institution that involuntarily institutionalizes the mentally ill without giving them adequate medical treatment for their mental illness is a mental prison and not a mental hospital; and, that substantive due process of law does not allow a mentally ill person who has committed no crime to be deprived of his liberty by indefinitely institutionalizing him in a mental prison." Morton Birnbaum, M.D., "The Right to Treatment," American Bar Association Journal, Vol. 46, p. 499 (May 1960) p. 503.

⁷³A curious omission in this listing of the rights of hospitalized people is the right to refuse treatment.

failure breeds failure.

"By definition, of course, we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively if often unthinkingly, reduce his life chances."⁷⁴

There is persuasive evidence indicating the mental patient is stigmatized in numerous ways while he is in, and after he is released from, the hospital. There are indications that stigma works to prevent the ex-patient from succeeding in society -- not only because of the way others see him, but because of the way he sees himself.

"Question: Did it seem to you that being a mental patient made any difference in getting along outside the hospital?

"Answer: Yes. You don't have any confidence in yourself. You're scared."⁷⁵

The stigma attached to being a mental patient may be even more debilitating than that faced by the criminal:

. . . For many the stigma of the mental hospital is more feared than the restraints of prison. Even seriously disturbed prison inmates may be reluctant to be transferred to a hospital setting. The mental illness role is resisted on the basis that dignity,

⁷⁴Erving Goffman, Stigma, Prentice-Hall, Inc., Englewood Cliffs, New Jersey, 1963, p. 3.

⁷⁵Original Interview data from a study on returning mental patients, Miller and Dawson, "Effects of Stigma on Re-employment of Ex-mental Patients." Mental Hygiene, Vol. 49, No. 2, April, 1965.

self-esteem, and chances for an earlier release would be seriously compromised.⁷⁶

Judges in the commitment court are often alert to the possibility of stigma.

JUDGE REPPY: . . . The problem of the stigma of commitment, I think, deserves a few comments. I find that to be a very real fear among the patients and members of their families. Despite the rather enlightened outlook that we say we have, I think at least the people who face commitment feel that it is going to be a stigma. So, if it is possible to handle a case in a way that does not result in commitment, we like to do that. And frequently we make continuances over a considerable period of time, as much as even three months, and release the party during the period of the continuation with usually a recommendation that the party continue conferences with his family physician, or with a psychiatrist, if they have the money.⁷⁷ (Emphasis added.)

As Judge Reppy indicates, however, the mental patient's financial resources may have much influence on the stigma he ultimately feels; for money frequently means the difference between outpatient care and incarceration.

Stigma dogs the former patient even in his relationship with the community services which have been established to help him. The Department of Mental Hygiene has found that community agencies (including mental health agencies!)

⁷⁶Seymour L. Halleck, "A Critique of Current Psychiatric Roles in the Legal Process," Law and Society, p. 15.

⁷⁷Senate Fact Finding Committee on Judiciary, Admission Care and Treatment, January 1965, p. 40.

discriminate against ex-state hospital patients:

At both sites visited by the project staff (especially at the pre-test site) a most pervasive finding is the tendency for help agents, both within and outside the psychiatric specialties, to treat persons with a "mental" or "state hospital" label in different fashion than persons with the same kinds of problems who do not carry these labels. For example, leave patients with economic and social deprivation are often not looked upon as persons, similar to non-patients, who require whatever services are available for persons with such problems, but rather as mental patients whose deprivation is a product of mental illness. Leave patients who have nutritional and various other health care problems are not perceived as needing the same public health services as non-mental patients with these problems. If the physical symptoms are recognized, they are assumed to be related to the mental illness.⁷⁸ (Emphasis added.)

In summary, stigma appears to affect every facet of the former patient's life. Of particular importance is the devastating effect on employability. The evidence from a recent study shows a dramatic reduction in the chances of the ex-patient:

While 36 percent of these patients had some type of employment prior to their admission to the mental hospital, fewer than 20 percent were employed in any way a year after their release

There was a severe downward shift in patients' occupational identities following their release from a mental hospital. For example, while 22 percent were white collar workers prior to

⁷⁸California Department of Mental Hygiene, Office of Program Review, Project No. 11 - Management of Services to Mentally Ill Convalescent Leave Patients: Study Site No. 1 August 1, 1966, pp. 12-13.

admission, only 10 percent were so classified at the time of leave-of-absence termination

Of those patients who felt stigma, 16 percent characterized this ex-patient status as "a club held over their heads" by relatives and others; 16 percent felt they suffered blocked or distorted communications with others; 35 percent experienced severe feelings of self-derogation and loss of self-confidence; and 33 percent indicated that being a former mental patient had directly prevented them from seeking, obtaining, or holding a job.⁷⁹

Can results such as these be justified on the grounds that the citizen was committed for his "best interest"?

- NOTE -

Mental health counselor and precommitment screening services in some counties are diverting some people from the commitment system. But these services do not even exist in many counties and when they do appear, they do not always have an impact on commitment rates. Despite California's \$20 million Short-Doyle program and rapid development of community mental health services, 13,618 people were still committed to state hospitals in 1964-65, compared to 15,811 in 1960-61 -- a decrease of only 14 percent. (Most of the decline was in the alcoholic category.)⁸⁰

⁷⁹

Miller and Dawson, op. cit., p. 287.

⁸⁰

Statistical Reports, Department of Mental Hygiene, Bureau of Bio-Statistics.

CHAPTER III

THE TREATMENT ISSUES

"If all doctors in California's State Mental Hospital spent all their working time with patients, each patient would get only 5 minutes of attention a day."

Dr. James V. Lowry⁸¹

1. THE PRESENT COMMITMENT SYSTEM FREQUENTLY LEADS TO INEFFECTIVE TREATMENT IN PSYCHIATRIC INSTITUTIONS.

Most knowledgeable professionals in the State agree that thousands of Californians are still inappropriately committed to psychiatric institutions. The Director of California's State Department of Mental Hygiene states that, "All too frequently mentally ill persons become unnecessarily involved in court procedures and are committed to a state mental hospital instead of receiving treatment on a voluntary basis in the local community."⁸²

The present commitment system assumes that a finding of "mentally ill" justifies involuntary placement in a psychiatric institution. In part, this assumption is based on a belief that the treatment to be provided in a psychiatric institution

⁸¹ "Mental Health Progress," Department of Mental Hygiene Bulletin, December 1965.

⁸² See testimony of Dr. James V. Lowry, Transcript of Hearing of Assembly Ways and Means Committee, Subcommittee on Mental Health Services, December 20, 1966, p. 44.

will help the patient and that what is being done is for the patient's "own good". This assumption pervades most commitment hearings. The officials are generally very kind and reassuring and they "process" the case as rapidly as possible to prevent trauma to the patient and speed him on his way to "treatment".

There is convincing evidence that in a large proportion of cases, the treatment provided in these institutions may not be helpful.⁸³, 84

In January 1965, the California Medical Association published a 135-page report on conditions in the state

⁸³"It must be reported that in 375 wards out of a total of 523 wards, almost 21,000 patients have no intensive treatment or rehabilitation activity. These patients are clean, have decent clothes, and are furnished good nutrition and baths, but are not motivated to return home." Department of Mental Hygiene, A Long Range Plan for Mental Health Services in California, p. M-4.

⁸⁴The Subcommittee's survey of all psychiatric facilities found that while drug therapy was widely used, the primary type of treatment for most patients was "milieu therapy" or long-term custodial care, i.e., 66 percent of V. A., 81 percent of state hospital, 56 percent of county hospital, 73 percent of private or proprietary, and 87 percent of the convalescent hospital patients were receiving primarily either "milieu therapy" or long-term custodial care. Only 8 percent of the V. A. patients, 4 percent of the state patients, 5 percent of the county hospital patients, 9 percent of the private or proprietary patients and 1 percent of the convalescent hospital patients were receiving primarily individual or group therapy.

hospital system.⁸⁵ The report was based on site visits by teams of physicians. That report raises serious questions about the "treatment" capabilities of these institutions. To summarize the C.M.A. report, it was found that without adequate staff, equipment, and space, most state hospitals are unable to provide modern treatment. Some of the problems are inherent in the location and structure of the hospitals, and it is unlikely that some of these difficulties can be overcome.

For example, the physical distance from the centers of population has placed great burdens on the functioning of the hospital. Recruiting professional personnel is particularly aggravated by the hospitals' geographic location. In their investigation of the DeWitt State Hospital in Auburn, the California Medical Association noted a painfully undermanned staff and added: "Many staff people live in Sacramento and commute (a distance of 35 miles) to work. Recruitment is made difficult because the cost of living is high in Auburn, the rate of pay is low, and the community is relatively isolated."⁸⁶

⁸⁵ California Medical Association, Observations and Comments Based on a Survey of California State Mental Facilities, January 18, 1965.

⁸⁶ Ibid, p. 28.

Similarly, geographic location has great bearing on the aftercare programs conducted by the hospital for the purpose of aiding patients in their readjustment to the community. In Mendocino State Hospital, the C.M.A. found that the facility's location "frustrates the return-to-the-community orientation of the hospital's program." Those patients from urban areas such as San Francisco pose special problems because rural Mendocino County is not their home community, and a "smooth post-hospital transition cannot be arranged for them as readily as for other patients."⁸⁷ Therefore, many patients whose homes are not within the area are penalized and are frequently returned for hospitalization because they are denied contact with those who could help them make a successful transition to community living.

Another problem resulting from the isolated nature of the hospital is the tendency toward professional stagnation. Without adequate access to the community and other qualified physicians and psychiatrists, the personnel within the hospital lack the benefits of close personal contacts with other colleagues in the field. In their individual evaluations of the state institutions, the C.M.A. frequently noted a lack of dynamism, research and experimentation in a

⁸⁷
Ibid., p. 37.

hospital's operations. Of DeWitt, the survey team said, "The prevailing feeling concerning this hospital was that it lacked a 'spark,' that it was not characterized by a therapeutic attitude, and that apathy and passivity were in great evidence."⁸⁸

Again bearing out the effects of such an insular atmosphere the C.M.A. team said of Stockton, "The fact that ten board-eligible psychiatrists on the staff have not completed their certification suggests that the threat of professional stagnation is a real one in this hospital."⁸⁹

The C.M.A. found a lack of proper supervision of therapy activities. In many of the hospitals investigated, ward physicians, psychologists, social workers, and psychiatric technicians were conducting therapy without guidance from staff psychiatrists. At Camarillo it was noted, "Most of the ward physicians have no specialized training in psychiatry and yet have the total responsibility of psychiatric evaluation, outlining of individual treatment programs and periodic evaluations."⁹⁰

Another obstacle to treatment is the overcrowded conditions so prevalent throughout the State's institutions.

⁸⁸ Ibid., p. 31.

⁸⁹ Ibid., p. 62.

⁹⁰ Ibid., p. 27.

Though most of the facilities are clean and tidy, many of them appear more like "sanitary dungeons."⁹¹ In at least half of the state's hospitals, the C.M.A. found that beds were placed so close together that the individual was denied any ready access to his personal belongings. Of the Metropolitan facility the team said:

In many units there are 100 patients to a ward which is patently too many even for custodial care, to say nothing of treatment. Beds are pushed so close together that there is scarcely enough room between them to permit a patient to get out of bed. It goes without saying that there is no room on these wards for individual lockers or for bedside tables. This overcrowded state. . . is dehumanizing and antithetical to acceptable patient care.⁹²

In some hospitals the C.M.A. noted a punitive climate and revealed the indiscriminate use of "seclusion orders"⁹³ in many hospitals. Commenting on Agnews, the C.M.A. stated: "The team was quite distressed over the indiscriminate isolation or seclusion of patients. There is a definite need for tighter control on the use of seclusion."⁹⁴ It was felt that the arbitrary use of this tool--regardless of the

⁹¹Ibid., p. 21.

⁹²Ibid., p. 39.

⁹³A seclusion order permits the placement of the patient in a small locked room.

⁹⁴California Medical Association, op. cit., p. 17.

existence of an emergency--tended to negate any progress which the patient may have made under therapy.

In order to maintain an orderly patient community, many hospitals were found to employ drug therapy to a very extensive degree.⁹⁵ Because of a lack of qualified therapists, it was necessary to keep acutely ill patients under heavy sedation. In some cases, the C.M.A. criticized this reliance on drugs as an expedient rather than a necessity. With regards to such procedures at Camarillo, the team stated: "There seemed to be excessive over-reliance on drug therapy which represents to us an attitude of benign restrictiveness and lack of patient orientation. We recommend that the orientation of the staff be more toward the individual treatment needs of patients."⁹⁶

Related to the use of chemotherapy is the proper utilization of electroconvulsive therapy. Though in most instances this technique was not found to be used indiscriminately, it was discovered that many hospitals did not administer the proper muscle relaxants prior to treatment and neglected to run routine x-rays once the process was completed. A dramatic evidence of this was pointed out at

⁹⁵ The Subcommittee's survey of state mental hospitals found that approximately two-thirds of all patients were receiving drug therapy.

⁹⁶ California Medical Association, op. cit., p. 28.

Stockton: "It is reported that five vertebral fractures following electroconvulsive therapy have occurred in the past year: it is conceivable that more occurred than [were] reported, since the patients are not given pre- or post-shock x-rays."⁹⁷ The fault seems to lie with a lack of equipment rather than with the hospital staff.

One of the most serious problems facing all of California's state hospitals is the critical lack of personnel at all levels. Almost without exception, the C.M.A. noted shortages in nurses, psychologists, psychiatric technicians and trained psychiatrists. Though available personnel seemed to be energetic and dedicated, too many times they are encumbered by clerical and housekeeping chores which cut down on valuable time which could be spent with patients. At Metropolitan, "The complaint of being understaffed and of being unduly burdened by paper work was heard repeatedly."⁹⁸ At Metropolitan, the team reported that there was only one therapist for every 380 patients. Serious understaffing at Patton was seen as a "tremendous obstacle" to proper treatment.⁹⁹

⁹⁷ Ibid., p. 63.

⁹⁸ Ibid., p. 40.

⁹⁹ Ibid., p. 59.

In conclusion, the major issue in the C.M.A. study seems to be the contrast between purely custodial care and a truly therapeutic community. A general comment made about the situation at Modesto State Hospital sums up the problem:^{100, 101}

Institutionalized type care, which is self-perpetuating, tends to deprive an individual of his freedom of action and freedom of choice. A paternalistic type of staff attitude, influences the patient's chronicity. The small number of physicians on the staff tends to deter the ongoing, active treatment program within the hospital and contributes towards the repetition of a vicious cycle of keeping things at the status quo.

Most of the problems of the state hospitals are longstanding and have been documented by the State Department of Mental Hygiene. It is not the purpose of this report to dwell on the internal inadequacies of the present state hospital system.¹⁰² The issue is the failure to achieve the objective of providing "treatment" to many people who are committed because "they are in need of treatment."

¹⁰⁰ Ibid., p. 25.

¹⁰¹ For a most incisive and revealing study of the dehumanizing effects of institutional living, see Erving Goffman's Asylums, Anchor Books, 1961.

¹⁰² The Department of Mental Hygiene's Office of Program Review has documented many weaknesses in the clinical, maintenance, business administration, and personnel aspects of the state hospital system.

Undoubtedly, there are some patients who are helped in these institutions and are discharged as improved. But for others it is a matter of adjusting to a new kind of status quo as a chronic long-term mental patient.¹⁰³

The Subcommittee's survey of California's psychiatric hospitals found the prognosis "poor" or "guarded" was applied to most patients (V. A., 82 percent; state hospitals, 61 percent; county hospitals, 40 percent; private or proprietary hospitals, 57 percent; convalescent hospitals, 65 percent).

2. HOSPITALIZATION MAY HURT RATHER THAN HELP

There is evidence that many institutionalized people could have been helped if they had only been able to take advantage of a better program. Here is where the policy of

¹⁰³"There is general concurrence that society tends to cast out as unfit its mentally ill members and demands protection from and for them; that in fulfilling society's requirement of protection we disable the patient, preventing his exercise of responsibility, allowing his skills to atrophy, promoting in him a sense that he is a victimized culprit; that the patient's resources for adaptation then become directed toward adjusting to custodial life. Adjustment to custody is sought for the patient through the efforts of the staff and when achieved has the status of a praiseworthy goal attained. But such an adjustment is inappropriate to community living and, rather than preparing the patient to return, radically interferes with his efforts to re-establish a life in the community." (Emphasis added.) John B. Deiter, Ph.D., et al, "Northwest Washington Hospital-Community Pilot Program" (Submitted to National Institute of Mental Health in application for a Mental Health Project Grant - July 1, 1961)

involuntary commitment for "treatment" becomes most questionable. A recent study of schizophrenic patients in Los Angeles indicates that hospitalization for these patients may actually hurt rather than help. Dr. Werner M. Mendel (U.S.C. School of Medicine), studied almost 3,000 schizophrenic patients and concluded that:

. . . Efforts at building more hospitals and training more treatment personnel have not resulted in a significant overall improvement of care for the large number of patients hospitalized for psychiatric illness. . . . Patients hospitalized for long periods of time show a clinical picture which erroneously has been attributed to the disease process. Rather, the observed deterioration of function is the outcome of prolonged hospitalization. The chronic, deteriorated, schizophrenic patient who vegetates in the back wards of our many state hospitals is the final outcome of an iatrogenic (doctor caused) condition resulting from long hospitalization superimposed on the schizophrenic illness. The evidence of the anti-therapeutic effects of prolonged hospitalization and the availability of the wide range of treatment services which permit care of severely mentally ill patients in situations other than total hospitalization, necessitates a changing conceptualization of the role of the hospital in a total treatment program.

. . . Since our study of 2,926 patients demonstrated that the rate of discharge from the hospital to the community was 75% regardless of the number of days the patient spent in the hospital and since we found that the rate of rehospitalization during the two-year follow-up period was 20.5% and did not vary with the number of days spent in the hospital during the index hospitalization, and since we observed that longer hospitalization tended to promote longer rehospitalization and more impairment of social and work function, we must seriously question the present conceptualization of the hospital as a method of treatment in the chronic schizophrenic patient. (Emphasis added.)

. . . Patients with mental illness cannot get well inside of a hospital. (Emphasis added.) Getting well requires the opportunity to adapt to reality as it presents itself outside of a hospital. If in doubt as to when the patient should be discharged from the total hospital, we should make the decision in favor of letting him go.¹⁰⁴

Other studies have proved the value of non-hospital "family treatment" techniques. These techniques emphasize that the "patient" is only one part of a family problem and that his bizarre behavior may be a very appropriate response to other family members.¹⁰⁵ In such cases removal of the "patient" and focusing on his treatment may be totally inappropriate.¹⁰⁶ Removal of the patient prevents scrutiny and intervention in the family problem, and in the non-medical problems that may underlie the "patient's" behavior. Considerable research and a large body of information is

¹⁰⁴Werner M. Mendel, M.D., "Brief Hospitalization Techniques," (unpublished paper).

¹⁰⁵For a dramatic and authoritative account of the ways that family difficulties can produce "sick" behavior, see R. D. Laing and A. Esterson, "Families of Schizophrenics," Sanity Madness and the Family, Volume 1.

¹⁰⁶. . . As long as schizophrenia was considered an organic disorder and a rather hopeless one, the therapist did little in the way of treating schizophrenic patients other than isolate them in large steel and concrete mausoleums euphemistically called hospitals." Don D. Jackson, M.D., "Family Homeostasis and the Physician," California Medicine, October 1965, p. 241.

now being developed on the effectiveness of "conjoint family therapy" as an alternative to hospitalization.¹⁰⁷

Jay Haley, editor of Family Process, states in a letter to the Subcommittee:

"... it seems to me to be logical that if a person becomes disturbed or goes mad in his family and then is pulled out of it and put on his feet and is sent right back into that situation unchanged, then he is likely to become disturbed and be hospitalized again. Yet for half a century this pattern has been assumed to represent a tragic worsening of a disease process within the person."

In the Subcommittee's one-day census of California hospital patients, it was learned that among state hospital

¹⁰⁷"In the admission office of a mental hospital the psychiatrist assumes that the person referred for hospitalization is the one who needs treatment. If the family is seen it is to get information about the patient and help the family adjust to the problem of having a relative hospitalized. At a later time the family may be seen to manipulate the milieu into which the patient will be discharged. The disease concept of medicine has focused attention on disorganization of function within a given individual. Clinicians have focused on the psychology or biology of the single person. Only in recent years has attention been directed to the social field and particularly its basic unit, the family.

"From the philosophy we will try to elaborate, and the approaches we have used, you may come to feel that we are not in favor of putting people into psychiatric hospitals. That is exactly the case! Mental health professionals more or less agree that psychiatric hospitalization is inescapably a regressive experience with far reaching destructive repercussions on the self-esteem of the patient, on the family's picture of itself, and on the patient's relationship with society. (Emphasis added.) Frank S. Pittman, III, M.D., et al, "Family Therapy as an Alternative to Psychiatric Hospitalization," Psychiatric Research Report 20, American Psychiatric Association, February 1966.

patients, the hospital believed counseling with the family was a needed treatment procedure in only about 1 percent of the cases!

Current mental health research indicates that for some people hospitalization is contraindicated for still another reason. Arlene K. Daniels, Ph.D., Project Consultant to the U. S. Army's Psychiatric Residency Training, in a letter to the Subcommittee, states that,

secondary gain (the benefits of becoming a sick person) may far outweigh, for the patient, the discomfort or deprivation connected to illness. Secondary gain is a special danger where difficult tasks may be avoided by accepting the "sick" label. The susceptible individual may not at first realize the high cost of trading the chance to avoid unpleasantness for the advantages of being declared sick. Unfortunately the adaptation to the sick role may become increasingly difficult to discard and a lifetime incapacity may be the eventual result of an illness which might have been temporary without hospitalization.

To minimize or avert such dreadful possibilities military psychiatry has developed strategies for denial of mental illness. Such methods are also used in community psychiatry. In both contexts, every effort is made to keep potential mental patients in their own units or homes until the stress situation has passed. . . . It is possible that hospitalization is not only incorrect treatment but in some cases dangerous to any hope of future recovery.¹⁰⁸

¹⁰⁸ For amplification see: Henry A. Segal, "Iatrogenic Disease in Soldiers," U. S. Armed Forces Medical Journal, November 1954, pp. 1657-62; Robert J. Glass, et al, "The Current Status of Army Psychiatry," American Journal of Psychiatry, CXVII, February 1961, 673-83; Eli Ginzberg, et al, The Ineffective Soldier, New York: Columbia University Press, 1959.

Another treatment problem stems from the fact that the "mentally ill" concept has apparently produced a mental health system which provides highly traditional medical types of service which do not focus on the non-medical problems that may be at the root of the disturbed person's difficulties. This is a particularly serious issue since most of the patients are from very low socio-economic groups and often have many nonpsychological, physical, employment, housing, and other practical problems. Although these "patients" frequently have non-medical needs, the program's leadership may not be oriented to respond to these multiple needs. Physicians, judges, nurses, psychiatric technicians, and social workers appear to be guided by the psychiatric medical model and a limited notion of "treatment". For example, an evaluation of social worker activity in the Department of Mental Hygiene's aftercare program concludes that:

There is a tendency for the Department of Mental Hygiene help agents to be inordinately preoccupied with psychiatric content and methodology, to the exclusion of physical, social and inter-personal deprivation. (Emphasis added.) As a result, professional time tends to be directed toward the patient who the staff members believe can be helped by having him talk about his problems and feelings. This is at the expense of those patients whose needs and capabilities are that of interaction on a more non-verbal level with a compassionate human being who can also assist in providing concrete services.¹⁰⁹

¹⁰⁹ California Department of Mental Hygiene, Office of Program Review Project No. 11 - Management of Services to Mentally Ill Convalescent Leave Patients: Study Site No. 1, August 1, 1966, p. 3.

It seems clear that present treatment programs tend to focus narrowly on mental problems and may not only fail to solve people's psychological difficulties but may actually compound and intensify their nonpsychological problems. In a recent 5-year study of 1,045 California post-hospital patients, Miller and Dawson found that:

71% of all released patients had been returned to the mental hospital at least once, and 24% had been re-hospitalized on the average of 4.4 times each. We found, confirming the findings of other studies, that approximately 85% of these released mental patients came from the lowest socio-economic class; that 65% had less than a high school education; that only 26% found any type of employment after their release, while 27% were totally dependent upon public welfare as their source of support.
(Emphasis added.)

Ex-patients often found their former way of life shattered beyond repair with each release from a state hospital. They underwent a constant drainage and depletion of their social resources with each state hospital stay.¹¹⁰

In view of the deficiencies in treatment programs and the questionable and often negative results, it is difficult to accept the notion that sending a wide variety of people

¹¹⁰ Dorothy Miller and William Dawson, "Worlds That Fail, Part II: Disbanded Worlds: A Study of Returns to the Mental Hospital," California Mental Health Research Monograph No. 7, California Department of Mental Hygiene, September 11, 1965.

to institutions against their wishes can be justified because "they are in need of treatment." There must be better ways. 111, 112, 113

3. THE NONPSYCHOTIC SENILE

The law states that, "no case of harmless, chronic mental unsoundness or mental deficiency shall be committed to the Department of Mental Hygiene for placement in any state hospital for the care and treatment of the mentally ill." 114

111 "We treat a sample of patients who ordinarily would be hospitalized immediately at the Colorado Psychopathic Hospital and we have been able to keep 95% of these patients out of the hospital during the acute phase and 85% in follow-up which has gone on for up to two years." (Emphasis added.) Letter to the Subcommittee dated July 6, 1966, from Donald G. Langsley, M.D., Director of Inpatient Service, Colorado Psychopathic Hospital.

112 "Only 10 percent of Russian hospital beds are occupied by patients with mental disease, vs. 50 percent in the U. S. The emphasis is on the Soviet version of Short-Doyle, i.e., outpatient clinics." "Medical World ... How It's Done in USSR," The Bulletin, December 5, 1963.

113 San Mateo County, California, a suburban community in the San Francisco Bay Area, offers comprehensive mental health services in its Public Health Department. Nearly eight thousand patients get service each year through the adult clinic, child guidance clinic, in-patient therapeutic community (a thirty-bed open service in the general hospital), day hospital, rehabilitation service, nursery school for disturbed children, delinquent and offenders treatment, alcoholic rehabilitation unit, research and evaluation service, and the consultation service. . . . And because of this comprehensive mental health service, the county's state hospital admissions have remained static while admissions from four other Bay Area counties rose sixty-one percent." Henry Weihofen, "Mental Health Services for the Poor," California Law Review, May 1966, Vol. 54, No. 2, p. 929.

114 Welfare and Institutions Code, Section 5571.

The Subcommittee's study of a sample of state hospital patients found that 28 percent of the resident population is over 65 years of age. The court study revealed that 20 percent of the persons brought before the commitment court were over 65. Thus, despite attempts at community placement, the influx of aged, senile persons into state mental hospitals continues. (The most dramatic exception to this trend was found in San Francisco County Hospital, where the survey found that while 17 percent of the population was over 65 years of age, only one aged person was being sent to the state hospital.)

The Legislature has been aware of the problem of inappropriate hospitalization of the aged for some time. Sixteen years ago, in 1950, the Governor's Conference on Aging raised questions about the "dumping" of aged persons into state hospitals. Following that, in 1953, the Assembly Social Welfare Committee under the chairmanship of Assemblyman Lanterman studied the problem and issued a report on the nonpsychotic senile and presented recommendations for change.

Several years later, in 1956, Assemblyman Lanterman reopened the question at a public hearing. "I think the Legislature has stated its opinion, the Department (Mental Hygiene) has issued order after order, and still there has

been this inappropriate placement of some of these aged people.¹¹⁵

In 1962, the Department of Mental Hygiene's Long Range Plan once again illustrated the problem and reported that at DeWitt State Hospital only 8.9 percent of the patients over 65 needed a psychiatric hospital.¹¹⁶

Then, in 1963, the Department of Mental Hygiene completed a two-year study entitled, "State Hospital Geriatric Problem," and reported that, "sizeable admissions in this age group are inappropriate."¹¹⁷

In 1964, the Assembly Ways and Means Subcommittee on Institutions found that the problem still existed. They found that:

Almost 3,000 people 65 years and older are committed to state mental hospitals for the first time each year. Almost 80 percent of these people die within a year of commitment.

This practice is socially and economically undesirable and should be halted.

. . .

¹¹⁵ Transcript of Hearing of Assembly Interim Committee on Social Welfare, Modesto State Hospital, September 19, 1956.

¹¹⁶ California Department of Mental Hygiene, A Long Range Plan for Mental Health Services in California, 1962, p. D-8.

¹¹⁷ California Department of Mental Hygiene, "State Hospital Geriatric Problem," January 18, 1963, p. 1

Extensive variations in the county aged commitment rate indicate that court procedures and policies are not uniform. This situation is similar for other classes of patients beside the aged.¹¹⁸

The Subcommittee's present study reveals that except in a few communities, elderly people are still being herded through commitment courts into state institutions. This report has indicated that placing the mentally disordered in state institutions is often a poor choice of treatment. . . . but many of these elderly people are not even mentally ill!

According to Dr. Robert Hewitt, "The best hope for reducing the number of non-mentally ill aged in our hospitals is to prevent them from entering in the first place."¹¹⁹ (Dr. Hewitt estimates that about 4,500 aged patients are improperly in California State hospitals.)

Why is this problem still unresolved?

In the Subcommittee's first public hearing in October 1963, Assemblyman Frank Lanterman raised the issue again and identified the commitment system as being partially responsible:

¹¹⁸ California Assembly Interim Committee on Ways and Means, A Summary Report on Health Care Services for the Aged, p. 17.

¹¹⁹ Testimony of Dr. Robert Hewitt, Chief Deputy Director, Department of Mental Hygiene, Los Angeles, September 10, 1964, as cited in report of the Assembly Interim Committee on Ways and Means, Final Report on Health Care Services for the Aged, April 1965.

I have been in the Legislature for 13 years and I was chairman of Social Welfare in 1953 and 1954, and this was one of my main concerns--to try and stop the commitment of non-psychotic seniles. We have been at it all this time. Every year, at the budget sessions, when we discussed the budget of the department in detail, I continually asked these questions. They are continually, shall we say, dealt with lightly. The point that I want to make is, perhaps, we are not getting at the source, and the source is the court commitment at the locality and the psychiatrists advice to the judge in these courts which allow a commitment of a non-psychotic senile. The extent of the senility may be a real problem for custody and care, but these people are not psychotic. The question is, then, are our courts partially responsible?"¹²⁰
(Emphasis added.)

There is evidence that better alternatives are available and that state hospitalization of the aged can be avoided. (It appears that the best results have been achieved in the Geriatric Screening Unit located in the Division of Protective Services of the Department of Social Welfare in San Francisco.)¹²¹

A statewide policy and program is required. At a recent hearing, Assemblyman Petris summed up the 16-year-old issue:

¹²⁰ Transcript of Hearing of Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, October 22, 1963, p. 26.

¹²¹ "In 1963, there were 473 admissions of elderly persons from San Francisco to state hospitals. In 1964, after the establishment of a 'Geriatric Screening Unit' this was reduced to 306. During 1965, only 40 elderly people were committed from San Francisco." Testimony of Dr. James Lowry, Transcript of Hearing of Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, December 20, 1965, p. 48.

. . . it seems to me, there is an impression, built up over the years, that, "Well, these people are old, they are senile, and there's nobody to care for them and nobody wants them, so let's get rid of them." Now the county supervisors in some counties encourage that policy because they don't like to face a bigger budget. The taxpayers are on their backs, so they take the easy way out. They use the state hospital as a dumping ground, is what it amounts to. A dumping ground for senior citizens that nobody else cares about or wants. One of these days I hope to be a senior citizen, Lord knows, I may wind up in that dumping ground. I have friends and family now, but they may both be gone. I may out-live everybody, who knows? And, just looking at it from that standpoint, is shocking to me. . . . There is a section in the law, as I recall, that says, "if a person doesn't have some kind of psychosis, you can't commit him," yet doctors, lawyers, judges, and members of the board of supervisors and other public officials are violating the law in committing these people.¹²² (Emphasis added.)

The law is being violated; medical opinion is being ignored; alternatives can be found; but still, whether or not an elderly person in California is committed to a remote hospital depends on the accident of geography. "To dump or not to dump" depends on the initiative of local judges and other local social agencies and officials. Unfortunately, many local communities have not displayed sufficient initiative to justify continuing a laissez-faire policy.

122

Transcript of Hearing of Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, January 18, 1966, pp. 38-39.

SUMMARY

General public acceptance of the system of easy commitment to state hospitals rests on the naive belief that "it's all for the patient's own good." It is painful to face up to the fact that the trade "your liberty for your treatment" is often a poor bargain. The public who uses the commitment system would like to believe that "it's the right thing to do." All the principal players--judges, doctors, social workers, and legislators would like to believe that system accomplishes the treatment objective. But no matter how the involuntary hospital commitment system is dressed up in medical terms--it is not the proper way to meet the needs of most of the troubled people now committed.¹²³

As one patient cried out while being ushered from a commitment court: "Why am I so miserable when you are all helping me so much!"

¹²³ The Subcommittee's observational study of commitment courts categorized the problems which resulted in the court hearing. In 21 percent of the cases, the observers could not discern the specific behavioral difficulty which had led to the commitment hearing; in 35 percent of the cases, family difficulty had led to the hearing; in 19 percent of the cases, difficulties with the law had brought the person before the court, while the remaining 25 percent of the cases were seen as being unable to care for themselves because of advanced age or physical incapacity. It would seem doubtful that involuntary institutionalization would solve or ameliorate many of these problems.

CHAPTER IV - PART A

RECOMMENDATIONS

This chapter outlines proposals for the new system. Chapter V discusses these proposals in greater detail and provides additional supportive information.

A PROPOSED NEW SYSTEM FOR CITIZENS WITH MENTAL DISORDERS

1. COMMUNITY EMERGENCY SERVICE UNITS

Most people who believe themselves to be mentally ill or whom others believe to be mentally ill, do have some kind of problem and may benefit from some kind of assistance.

Whether they seek help voluntarily or whether others (family, police, friends, physicians) initiate the action to secure help, there should be a place, close to home, where an individual's problem can be properly analyzed, where appropriate help can be offered, or where arrangements can be made to secure such services as may possibly be helpful.

With the exception of criminal offenders,¹²⁴ mentally disordered persons may reach needed services through Community Emergency Service Units (hereafter referred to as the E.S.U.).

¹²⁴See Chapter IV, Part B, for details of the involuntary system for mentally disordered criminal offenders.

The E.S.U. is the central feature of the proposed new system. It replaces the commitment court and is designed to provide a wide variety of voluntary services quickly without stigma or legal disabilities.

A. FUNCTIONS OF THE E.S.U.

The E.S.U. will provide the following services:

1. Medical, psychological, social, and legal evaluations as required. The evaluation will be for the purpose of answering the questions: What is the problem? What services may be of value? Who can best provide the needed services?

In most cases the evaluation will be accomplished without detention and contact with the E.S.U. staff should take place in the E.S.U. offices or in the citizen's own home.

If absolutely necessary (similar to present law) gravely disabled, or overtly destructive citizens who, although they have committed no criminal offense, appear to present an immediate threat to the safety of others, may be involuntarily detained by the E.S.U. for 72 hours in an approved licensed hospital. Such hospitalization shall be for the purpose of completing the evaluation of the needs of individuals and

providing other E.S.U. services.¹²⁵

2. The E.S.U. will provide short-term emergency counseling, suicide prevention counseling and such other emergency medical, legal, or social services as may have value in assisting individuals in crisis situations. These direct services will be available on both an inpatient and outpatient basis.

3. The E.S.U. will provide advice about additional services that may be required and will assist the citizen in contacting these services. The emphasis in E.S.U. shall be to refer individuals to a wide range of community services on a voluntary basis. Persons referred by E.S.U. to state and community hospitals or other services should, with professional advice, have freedom to select their physician, hospital, or other services; shall be free to reject treatment, and shall be free to terminate treatment at any time.

4. The E.S.U. will also investigate and clarify the financial resources available in each case (i.e. Medicare, insurance settlements, prepaid health benefits, private

¹²⁵See Chapter V for further discussion of existing detention powers. (Gravely disabled persons are defined as so incapacitated as to be unable to communicate or feed, clothe, or shelter themselves. Overtly destructive citizens are defined as behaving in such an uncontrolled manner as to cause law enforcement or E.S.U. officials to believe that their acts present an immediate and substantial danger to the safety of others.)

estate, etc.) The E.S.U. will assist individuals to make maximum use of all their existing resources to secure the services they need.

5. The E.S.U. will authorize the inclusion of certain persons in the State Medi-Cal System.¹²⁶ Those low income citizens who are now ineligible for mental health benefits under the Federal Medicare program because they are below age 65 and who are also ineligible under the State Medi-Cal program because they do not meet the income or welfare category requirements present a special problem. Whereas people with their own funds or Medicare and welfare recipients are now able to select and purchase services from a variety of "vendors", other low income people now have no choice but to use the state hospitals (or in some communities certain local services funded primarily by the State through the Short-Doyle formula).

In the proposed system, if the E.S.U. evaluation determines that the citizen meets certain income criteria and has such mental health problems as could lead to state hospitalization, he will be included in the State Medi-Cal program as a "mental health services" recipient and will be entitled to receive the inpatient and outpatient services of his choice -- with prior authorization from the E.S.U. (State hospitals will continue to be available to all residents of

¹²⁶See Chapter V for discussion of Medi-Cal benefits and cost implications.

California who desire such services after E S U. evaluation. But no person should be admitted to a state hospital without a referral from an emergency service unit.)

6. The E.S.U. may in some cases issue certification forms to permit the involuntary placement of certain citizens in specified treatment facilities for a maximum of 14 days, for crisis treatment. (No non-mentally disordered citizen shall be involuntarily hospitalized in California unless such a certification form has been issued by the E.S.U.) Certification forms will be issued only under the following four conditions:

- a- the citizen's personal physician and/or a physician associated with the E S U. must affirm in writing that the citizen is gravely disabled, or exhibits such destructive behavior that he appears to be an immediate threat to other persons, and has refused to accept treatment on a voluntary basis;
- b- the case has been evaluated by the E.S.U. staff; there is agreement as to the individual's need, and all other alternatives have been exhausted;
- c- the facility (state or local hospital) in which the individual is to be "detained for crisis treatment" can actually provide treatment (is licensed by the State and meets American

Psychiatric Association minimum standards).

- d- A physician associated with the crisis treatment facility accepts responsibility for supervising the individual's treatment and countersigns the certification form. (Certification forms will be sent to the State Department of Mental Hygiene for analysis and periodic reporting.)

At the time of admission, the patient must be informed of his legal rights verbally and in writing as follows: If at any time from the date of admission, the patient or any relative or friend requests the physician in charge for a hearing on the need for hospitalization, the physician must notify the nearest superior court immediately and the court must fix a hearing within four days.

Whether or not a hearing has been requested, at the end of 14 days the citizen shall be free to leave, or may remain for additional treatment on a voluntary basis. If the citizen is still gravely disabled, legal guardianship procedures may then be initiated through the courts.¹²⁷

- 7. The E.S.U. will also have responsibility for

¹²⁷See Chapter V for description of guardianship proposals and for a discussion of suicidal and "potentially" dangerous persons.

investigating and protecting the rights and property of citizens being detained for 72 hours or 14 days, and all those for whom public guardianship has been assumed. The E.S.U. may contract with the Department of Social Welfare (Division of Protective Services) and the Department of Mental Hygiene (Bureau of Patient Accounts), private attorneys, and other state or local agencies to perform these services.

8. The E.S.U. will provide student placement and training opportunities for professional and non-professional workers and will perform research activities in the medical and behavioral sciences. For these purposes, wherever possible, the E.S.U. will have connections with universities and colleges.

- NOTE -

No legal disability of any kind shall be incurred by non-criminal citizens using E.S.U. services and other than statistical reports, all personal records will be confidential.

B. ORGANIZATION OF THE EMERGENCY SERVICE UNITS

In varying degrees, elements of the E.S.U. now exist in a variety of forms under different sponsorship in many communities. Some of these services are being provided by Short-Doyle clinics, state mental hygiene clinics, mental health counselors, state hospitals, county hospitals, County Health Departments, geriatric screening units, suicide prevention agencies, welfare agencies, etc. But there is no statewide system.

Citizens are treated differently in different communities and as a result commitment rates vary widely.¹²⁸

Since the proposed new state laws will apply to all citizens, a statewide system must be established to guarantee equal treatment. It is proposed that legislation as outlined in this chapter be enacted in the 1967 General Session to take effect July 1, 1968. By that date Emergency Service Units should be operating throughout the State.

1. The State will contract with local Mental Health Departments; local public and private clinics, hospitals, universities and colleges, or other agencies to provide specific E.S.U. services as set forth in legislation. Wherever possible, the State will contract with existing agencies now performing similar services. The various E.S.U. services need not be provided by a single local agency, and any community may incorporate several agencies in applying for an E.S.U. contract, provided they can offer a coordinated program.

2. If local agencies are unable to provide E.S.U. services, the State may provide all or part of these E.S.U.

¹²⁸Persons who are committed constitute 62 percent of all state hospital admissions in California, however, the proportion of committed persons vary from county to county. For example, 90 percent of the persons admitted from San Diego were involuntarily committed, while among all persons admitted from Lake County only 11 percent were committed.

services through the network of state mental hygiene clinics, day hospitals, state hospitals, social welfare, health and other functional units of state agencies. (State hospitals that may be providing E.S.U. services will establish separate units within the hospital for this purpose. Each of these units will have its own administrator responsible to the Department's Division of Local Programs.)

C. ADMINISTRATION

Any reduction in involuntary commitments of large numbers of persons who were indiscriminately placed in psychiatric institutions poses the question: "What is to become of these people who so often need housing, medical, employment, welfare and other services?" In the past, large "psychiatric" institutions attempted to meet all these needs, but the facts show that the policy of "lumping and dumping" is legally, medically and socially unsound.

Since the concept of "mental illness" is related to such a variety of known and unknown causes, it seems clear that if individualized rather than mass solutions are to be offered, it is essential that several professional disciplines be involved in developing standards and controls for the proposed new program.

The present levels of professional knowledge and technology in the human service fields should produce a

high degree of modesty within the psychiatric, psychologist, and social work professions. There are few simple answers to the multiple problems of those who now come before the commitment courts and it is important to avoid the old error of casting all these problems into a single narrow pattern of service. Many different services will be required from various agencies and professional practitioners.

1. It is proposed that there be a Program and Standards Board for Community Emergency Service Units. The Board will be composed of prominent mental health experts. The Board should contain at least one psychiatrist, social welfare expert, psychologist, sociologist, legal expert, social research methodologist, and representative of the public. Consistent with legislative intent, the Board should formulate policy and adopt standards for the operation of Community Emergency Service Units. The Board should have authority to give or withhold final approval on E.S.U. contracts, act as a review and evaluation body, conduct administratively independent research and report yearly to the Legislature. The Board should begin its work by July, 1967 -- one year before the new program becomes operational.

2. It is proposed that the Department of Mental Hygiene (Division of Local Programs) administer the proposed program to execute legislative intent and Program Board

policies. The Department, using its community organization specialists, planning and research divisions, and such other personal as may be appropriate, shall assist local communities in designing applications for E S.U. contracts for Board consideration.

3. Members of the Board shall be appointed by the Governor, the Speaker of the Assembly and President of the Senate. They shall be compensated for their expenses and shall employ a coordinator and such secretarial services as may be required.

D. FINANCING THE EMERGENCY SERVICE UNITS

Funds for E.S.U. services will come from the following six sources:

1. Medicare. Those over 65 (about 1/4 of those who will require E.S.U. services) can use Medicare benefits to pay for certain E.S.U. services (i.e., medical diagnosis and hospitalization in Medicare-approved hospitals).

2. Persons with certain prepaid health policies and those with adequate personal financial resources will be expected to pay for E.S.U. services (on a sliding scale basis).¹²⁹

¹²⁹See Chapter V for discussion of "fees".

3. All welfare recipients and other Medi-Cal beneficiaries will have all or most of their E.S.U. services paid from the State's Health Care Deposit Fund (50/50 State and Federal monies).

4. Other low-income citizens not eligible for federally assisted Medi-Cal will be included in the Medi-Cal program as "mental health services" recipients. Services rendered should be reimbursed using existing billing procedures through the State's fiscal intermediary (such as C.P.S.)

5. Federal funds for operating "Community Mental Health Centers" (at least \$2 million in 1967-68) will be used to augment E.S.U. services. The "State's Plan" for utilizing these federal funds should give the highest priority to E.S.U. services as the primary element in the State's new program for the most critical portion of the population.

6. If any additional funds should be required to cover the State with effective E.S.U. services, state funds will be used because E.S.U. services are specifically intended to prevent inappropriate placements in state hospitals. In the new system, counties will not be expected to participate beyond their present expenditures in the operating costs of E.S.U.-type services. County funds now allocated to certain E.S.U.-type Short-Doyle programs, mental health counselor or observation ward programs will be placed in California's

Health Care Deposit Fund to be used for the specific purpose of helping to pay for E.S.U. services for Medi-Cal recipients.¹³⁰

2. A VARIETY OF AVAILABLE SERVICES - ON A VOLUNTARY BASIS

A. FINANCIAL ACCESS TO THE "MAINSTREAM"

As has been indicated, citizens with mental disorders may require a wide variety of medical and non-medical services. There is considerable evidence that persons with sufficient financial resources of their own are often able to secure the services they need on a voluntary basis, rather than going to state hospitals. There is also evidence that these non-state services are at least as effective as state hospital services. (Non-state hospital services are often more intensive, of shorter duration,¹³¹ produce less dislocation, impose no legal disabilities, carry less stigma, and as a result are often less costly.)

¹³⁰See Chapter V for additional discussion of financing and non-E.S.U. Short-Doyle services.

¹³¹The Subcommittee's one-day census of California's psychiatric hospital facilities found that the average length of stay for short-term patients (less than 90 days) was as follows: V.A. hospital, 33 days; state mental hospital, 37.7 days; county hospitals, 11.1 days; private and proprietary hospitals, 18.6 days and convalescent hospitals, 25.8 days. The average length of stay for long-term patients (over 90 days) was as follows: V.A. hospitals, 2.3 years; state mental hospitals, 3.8 years; county hospitals, 7.5 months; private or proprietary hospitals, 9.8 months; and convalescent hospitals, 1.4 years.

As has been stated, one of the functions of the E.S.U. will be to enable lower income citizens to purchase the community services they require. This principle of shifting state responsibility and funds from the time a person enters a state hospital to the time that diagnosis establishes the fact that special services are needed, is now being employed successfully in California's new mental retardation program.

B. REDUCING DELAY AND RED TAPE BARRIERS

In addition to helping people to gain access to a variety of needed services by increasing their purchasing power, the E.S.U. will also assist individuals with critical mental disorders to cut through agency red tape and "waiting lists."

Some of the citizens coming to the E.S.U. will have urgent problems. People with acute problems may need immediate help. (Having the funds to pay for services is of little value if there is a long waiting period before services will be given.)

To help overcome this difficulty, the E.S.U. will render short-term (72 hour) crisis services and then, only if an individual's needs are still acute, they will identify the person for "emergency priority" and will assist him in contacting the agencies and securing the services he needs. All agencies receiving state funds will be required to honor the "emergency priority" status. Other agencies will be

requested to respect the critical nature of the problem and will be urged to move these citizens to the "head of the line."

State hospitals will continue to be available for emergencies but should be utilized only when other alternatives have been exhausted or in those cases where the state hospital offers the treatment of choice for the individual.

C. A VARIETY OF SERVICES

The E.S.U. evaluation will consist of an analysis of the medical and non-medical needs of the citizen and will attempt to assist individuals and families to contact the many services required -- including: hospitals, clinics, social welfare, employment services, financial counseling, recreation, vocational rehabilitation, housing agencies, senior citizen centers, visiting nurses, sheltered workshops, legal counseling, civic and ethnic fraternities and organizations, child welfare services, etc.

Many mentally disordered persons may require contact with various expert professionals over a long period of time. The E.S.U. is not designed to provide long-term services. (If the E.S.U. staff were to assume this responsibility, they would soon become loaded down with long-term cases and would no longer be able to fulfill their vital functions as the

central intake and emergency service mechanism in the State's mental health system.) In those cases where long-term help and counseling is required to assist a mentally disordered person to remain in the community and use the various services he needs, the E.S.U. will enlist the services of the Department of Social Welfare's Division of Protective Social Services, the Short-Doyle clinics or other agencies or individual practitioners capable of assuming continuing responsibility for assisting the troubled individual or family.

D. THE DIVISION OF PROTECTIVE SOCIAL SERVICES

The Department of Social Welfare's Division of Protective Social Services (formerly Bureau of Social Work, D.M.H.) has responsibility for providing casework counseling services to prevent the hospitalization of mentally disordered persons and to assist those who have been hospitalized in re-establishing themselves in the community. In the past this organization was funded solely by the State and its services were limited to ex-state hospital patients placed on "leave of absence." As a result of the recent transfer of the organization to the Department of Social Welfare, federal funds are now available to permit an expansion of the program to provide pre-hospital services to any person requiring such services. The organization now has over 300 trained psychiatric social workers in 35 local offices and constitutes

the largest single professional social work counseling resource in California. This Division should be utilized as one means of providing long-term assistance to mentally disordered persons in the community. The E.S.U. and the local Protective Services Division offices will be expected to develop a system for coordinating their services on a case to case basis as required.

3. CONVERTING STATE HOSPITALS TO HIGH QUALITY, OPEN HOSPITALS

Within the next few years a series of steps should be taken to modernize California's state hospitals.

A. CHANGING THE STAFFING STANDARDS AND FINANCING FORMULA

At present state hospitals for the mentally ill are operating on a staffing pattern authorized in 1952. During the past 15 years there have been many changes in treatment concepts. The nature of the state hospital's population has also been changing and will change even more rapidly as a result of the proposed new system. (State hospital populations can be expected to decline more rapidly than during the past few years; fewer geriatric and alcoholic patients will be admitted; many schizophrenics and other diagnostic categories will be served in their own community hospitals and on an outpatient basis.)

The Department of Mental Hygiene is currently re-evaluating

its staff standards and preparing proposals for legislative consideration. The Legislature should analyze these proposals in the light of the proposed new system and should endorse state hospital staffing standards that would permit these institutions to provide higher levels of service.

Achieving this higher standard may not require additional state funds.

Under the present staffing-financing-workload formula, the number of staff positions is tied to the number of patients. As a result, as patient population declines so does the number of authorized positions and vice versa. One result of this policy is that the quality of the program cannot improve. Tying staff positions to the number of patients guarantees the status quo. Furthermore, as the C.M.A. study of state hospitals indicates, this policy may also provide an incentive to keep beds inappropriately filled.¹³²

It is proposed that as a first step in upgrading state

¹³²"We tend to make a blanket judgment that hospital administrators are prone to keep beds filled in order to justify future budgetary requests. The prospect of a reduced staff at Patton would almost justify such a maneuver. The staff should not be penalized for its success in returning patients to the community." California Medical Association, Observations and Comments Based on a Survey of California State Mental Facilities, January 18, 1965, p. 59

hospitals, modern standards be adopted and the operating budgets of the state hospitals be held close to the 1966-67 level -- despite a declining hospital population. With the advent of new Medicare options for the aged, and especially after the Subcommittee's proposed new program becomes effective (July 1968), state hospital population should decline quite rapidly. To the extent that this occurs, the state hospitals should be able to achieve a high standard of service within the next few years with little additional state expenditures -- other than normal salary increments. (At such time as the state hospitals have achieved the new standard, the Legislature may wish to review and alter this financing approach.)

It is further recommended that the Director of the Department be permitted greater flexibility in the use of budgeted funds to accomplish this objective. The line item budget should be replaced by a program budget -- at least until such time as the higher standard of service has been achieved.

B. CONVERTING TO "OPEN HOSPITALS"

In the proposed system state hospitals may be serving some involuntary patients referred by the E.S.U. for 72 hours (E.S.U. services) or for 14 days (crisis treatment). With these limited exceptions, after July 1968, no citizen can be

involuntarily sent to state (or non-state) hospitals.¹³³

In the proposed system, state hospitals will accept only those citizens referred by the Emergency Service Units and with the exceptions noted above, these citizens will be voluntary patients in every sense. They will not be kept in locked wards, will have the right to use the phone, to correspond with whomever they wish, to refuse treatment or to leave the hospital when they wish (after signing a release form and making such arrangements as may be required to pay hospital bills and to satisfy the usual community hospital release procedures customary for non-psychiatric patients).

The therapeutic value of the "open hospital" has been clearly demonstrated and documented. Patients will participate more actively in treatment, will follow medical advice, hospitalization will be for shorter periods of time, and the many debilitating effects of involuntary treatment will be avoided.¹³⁴

C. STATE HOSPITAL RELEASE POLICIES AND POST HOSPITAL SERVICES

¹³³State hospitals may also care for some mentally disordered criminal offenders involuntarily committed by the courts (See Chapter IV, Part B). These persons will reside in separate protective custody and treatment units.

¹³⁴See Chapter V for a more complete discussion, details, and examples of the "open hospital."

The elimination of legal commitments and the use of the voluntary admission procedure will not only improve the internal character of the hospitals but will also eliminate the legal "hold" of the hospital on all released patients. (At present there are about 21,000 citizens on "leave of absence" from state hospitals. The "leave" status enables the involuntary rehospitization of these citizens without need for any legal proceedings. In fact they are on parole.)

This policy interferes with modern therapy by undermining a patient's confidence, depriving him of civil rights, placing him apart from other persons and making re-adjustment in the community more difficult.

After July 1968, citizens will no longer be involuntarily committed to state hospitals "for treatment" and the legal authority to place such patients on "leave of absence" will automatically terminate.

To provide for a continuity of service to patients who leave the hospital, all patients should be offered such community social services as they may require and desire.

Whenever possible, it would be desirable if these post-hospital services could be provided by the same professional person who has assumed continuing responsibility for the case. (The Division of Protective Social Services worker, the Short-Doyle worker, the family physician, or

other professional in the community who was involved in the patient's initial hospitalization.

- - - -

When these steps have been taken, state hospitals as we now know them, will no longer exist.

CHAPTER IV - PART B

A PROPOSED SYSTEM FOR MENTALLY DISORDERED PERSONS WHO ARE CRIMINAL OFFENDERS

The Subcommittee's study has focused on providing community service on a voluntary basis for mentally disordered persons who might otherwise be inappropriately committed. But some mentally ill persons may be criminal offenders, and some of these may be assaultive. A goal of major importance in coping with mentally ill persons who are criminal offenders is to guarantee community safety. Once public safety has been achieved, such persons should receive the medical and other treatment they may require. The proposals are designed to accomplish these safety and treatment objectives through the use of the criminal courts. These courts have well developed procedures for guaranteeing that assaultive persons are identified and for securing community safety while protecting individual rights. The courts also serve to reroute some people, perceived as criminals by law enforcement officers, who need treatment rather than confinement.

It should be noted at this point that these proposals will not result in placing the criminal label on persons who under current law are mentally ill and are committed as such. (In fact many of these persons, who are now merely assumed to be dangerous, will receive services on a voluntary basis with

no stigma or legal disabilities.)

These proposals deal with persons who are criminal offenders under current law and who, by reason of suspected mental illness, are now transferred to the Department of Mental Hygiene for custody and treatment.

The proposals leave the current criminal law intact (while recognizing that there may be deficiencies in that law beyond the scope of this study.) Under existing law, however, there are instances in which criminal courts or correctional facilities can remand a suspect or a prisoner to the superior court for a commitment hearing. As the report indicates (Chapter II) the current commitment procedures are seriously deficient. Some changes in these procedures are needed. Other changes are proposed to either (a) provide better facilities than now exist for confinement of criminal mentally ill persons, or (b) to give court officers some practical alternatives in dealing with mentally ill persons which are not fully spelled out under current law.

A. IDENTIFYING DANGER TO THE COMMUNITY

A major purpose of criminal law is to specify acts which the community is unwilling to tolerate. The criminal courts have the task of determining whether or not an offense has been committed and whether or not the offender should be removed from the community. When the court makes this

judgment it is in fact measuring the degree of danger to the public safety involved in permitting the offender to remain in the community. These two factors -- verifying the criminal act and weighing the danger to the public safety -- are the very heart of the process.

Therefore, with the exception of some persons (See Part A, this Chapter, for 72-hour, 14-day and guardianship proposals, and Part B for defendants incompetent to be proceeded against and not guilty by reason of insanity) no person should be confined against his will unless his behavior is criminally prosecuted, unless he is found guilty, and unless the court believes that the public safety would be jeopardized by permitting him to remain in the community.

B. THE JUDICIAL PROCESS

The alleged criminal offender must not be deprived of due process guaranties on the grounds of suspected mental illness. Except in cases of inability to stand trial by reason of mental disorder,¹³⁵ the offense must be proven and not simply charged. The rules of evidence, criminal procedure, and constitutional law should govern prosecution of mentally disordered offenders as well as "normal"

¹³⁵See p. 111 for amplification.

criminal suspects. The instrument of proof shall be the criminal courts. At present mentally disordered offenders are treated as second-class citizens in commitment courts that often fail to provide due process.

1. Acquittal

If the defendant is tried and found not guilty, he should be dismissed. (The court may suggest that an acquitted person seek mental health services and may provide him with information about such services.)

2. Not Guilty by Reason of Insanity

Should the defendant wish to plead not guilty by reason of insanity, he may do so as per current law. (The choice of plea is his alone.)

The M'Naghten "right and wrong" rule premised that a defendant who did not know right from wrong at the time of the act cannot be punished for commission of the act because he lacked the state of mind for criminal intent. That the defendant may "win" on this plea does not mean that he may not be a danger to the community and in need of confinement and treatment. He did the criminal act. Under current law, a suspect who "wins" on a plea of not guilty by reason of insanity is remanded to the sheriff for custody and a commitment hearing. It is recommended therefore, that defendants who successfully plead not guilty by reason of insanity be given

a separate trial on the issue of current mental condition. This is no change in the current sequence of actions except for the recommendation that this trial, unlike the current commitment hearing, should afford the defendant specific rights including but not limited to: right to counsel, to discovery of evidence contained in the observation ward and/or the E.S.U. evaluation records, a jury trial, a unanimous verdict, and a review of an adverse decision. The only issue in this trial is current sanity. If the defendant is found not to be mentally ill, he should be released. If the judgment is that the defendant is presently mentally ill, he may be placed on probation or confined in a security treatment facility of the Department of Mental Hygiene.¹³⁶ (This is identical to current process except for the improved legal procedure.)

Except in special circumstances, (see "Special Release Procedures") treatment should be for no longer than the maximum sentence for the crime with which the mentally

¹³⁶The defendant must receive treatment. Without treatment the hospital would simply be a jail. To punish the mentally ill in such fashion would be a step backward. This concept has found recent expression in the case of Rouse v. Cameron, Court of Appeals, District of Columbia, 10/10/66 (not yet reported) which held that a criminal defendant, involuntarily committed to a mental hospital upon acquittal by reason of insanity, has the right, enforceable by habeas corpus, to adequate treatment, and that continuing failure to provide suitable and adequate treatment cannot be justified by lack of staff or facilities.

disturbed offender was originally charged. Should he regain sanity, the Department of Mental Hygiene must release him.

3. Defendant Not Competent to be Proceeded Against.

When at the motion of either the judge, the prosecutor, or the defense attorney it appears that the defendant is not competent to be proceeded against, criminal proceedings should be suspended. This may be done at any time from arraignment until final judgment. This is the current law under Penal Code Sections 1368 and 1369. In these cases, a separate determination is now made as to the defendant's mental condition.

It is recommended that the separate trial be retained and that the procedure for it follow that recommended by the Commissions on Insanity and Criminal Offenders.¹³⁷

(1) The party claiming the incompetency, or the people if the proceedings were instituted upon the court's motion and over the protest of the defendant, has the burden of proving such incompetency and must open the case and offer evidence.

(2) The opposing party may then open his case and offer evidence.

(3) The parties may then respectively offer rebutting testimony only, unless the court, for good reason in furtherance of justice, permits them to offer evidence upon their original cause.

¹³⁷ California, Board of Corrections, Special Commissions on Insanity and Criminal Offenders, Second Report, November 15, 1962, p. 42.

(4) When the evidence is concluded, unless the case is submitted to the court or to the jury or either or both sides without argument, the party seeking to prove incompetency may commence and may conclude the closing argument.

(5) If the indictment or information be for an offense punishable with death, two counsels on each side may argue the case. In other cases the argument may be restricted to one counsel on each side.

(6) If the trial is by a jury, the court then must charge them stating all matters of law necessary for their information in giving their verdict.

It is further recommended that this trial, as with the separate trial which follows a successful plea of not guilty by reason of insanity, afford the defendant the right to counsel, to discovery of evidence contained in observation ward and/or the E.S.U. evaluation records, a jury trial, a unanimous verdict, and a review of the decision.

If it is found that the defendant is not competent to be proceeded against, he should be placed directly into a treatment facility of the Department of Mental Hygiene. The defendant should be returned to the criminal court for trial when the treatment facility considers him restored to competency. (This leaves current law unchanged.) Excepting in special circumstances (See "General Release Procedures") the defendant can be held no longer than the maximum sentence for the crime with which he was charged.

4. Guilty

If the defendant is tried and found guilty and the

judge determines that the public safety will be jeopardized unless the defendant is placed in custody, the felonious defendant should be sentenced to the Adult Authority for evaluation and appropriate placement and treatment. (This is current law.)

The misdemeanant perceived as mentally disordered may be sent to the Department of Mental Hygiene or to the E.S.U. for 14 days observation and evaluation. If the Department of Mental Hygiene reports to the court that the person is not mentally ill, the court may dispose of the case according to customary practice for misdemeanants. If the Department of Mental Hygiene reports a finding of mental illness, the court may commit the defendant to the Department of Mental Hygiene or to a local treatment facility. He should be held therein no longer than the maximum sentence for the misdemeanor of which he was found guilty except in special circumstances. (See Special Release Procedures, Section C.)

5. Probation

Mentally disordered offenders may be sentenced to probation instead of custody in the same manner as other offenders. Conditions of probation may include cooperation with E.S.U. staff and the use of voluntary mental health services.

C. SPECIAL RELEASE PROCEDURES

There are two situations in which special provision may need to be made for the person whose sentence at the security treatment facility has ended. These circumstances are now provided for by the language of Penal Code Sections 2960-2964 which state that before discharging any prisoner who may be "insane" the warden shall notify the superior court which shall arrange for a medical examination of the prisoner. If the prisoner is found to be "insane" the court must order him to a state hospital. This language affords only one solution to a problem which can arise in two quite different fashions. It is proposed therefore to distinguish the persons who are gravely disabled at the end of sentence from those who are criminally insane.

1. Gravely Disabled

There will be people who, as the result of physical or mental deterioration, or both, will, at the time of their release from a security treatment facility, be incapable of carrying on transactions necessary to survival and otherwise providing for such basic needs as food, clothing, and shelter. For these people it is proposed that the current Penal Code Sections 2960-2964 continue to be used, or that the medical director of the security treatment facility request that guardianship be established upon the prisoner's release. This latter alternative would be accomplished

through the superior court either on motion of the local E.S.U., as in the case where the Crisis Unit requests guardianship, or on motion of the Department of Mental Hygiene or the Department of Corrections.

2. The "Criminally Insane"

In some situations, an inmate of a security treatment facility who is approaching the end of his period of confinement will be considered a substantial threat to the physical safety of others by reason of insanity. For these persons the following new procedures are proposed.

The power to begin proceedings for extending confinement can attach only to those offenders who have already been convicted at least once of a crime of violence, or who have committed violent acts against others since their imprisonment. The proposed procedure can be exercised only at the end of the term currently being served.

The standard for exercise of the power should be 1) a substantial risk of the commission of a further crime of violence, 2) as measured by previous criminal history and such other factors as may be relevant, 3) caused by insanity. These points, taken together, shall constitute "criminal insanity."

There should be procedural guarantees encompassing the following matters to protect against error: 1) The Adult

Authority (or the Department of Mental Hygiene in the case of convicted misdemeanants) must within, a stated period before the end of the term fixed by law, certify the inmate to the superior court for a trial on the issues tendered by the standard set forth above. 2) The certification should be accompanied by a statement setting forth the reasons why the inmate comes within the standard. 3) The trial should afford specific rights including but not limited to: right to counsel, right to discovery of evidence contained in the Adult Authority (or Department of Mental Hygiene) records regarding the inmate's activities and treatment in the security treatment facility that relate to dangerousness and insanity, a right to a jury trial and a unanimous verdict, a review of an adverse decision, a limited additional confinement (perhaps a year) after which further confinement would require re-certification, and a requirement that the Adult Authority (or Department of Mental Hygiene) release the inmate should he regain his sanity.

These proposed changes in criminal court procedures should serve to separate dangerous persons from the community for appropriate placement and treatment, without violating their legal rights.

CHAPTER V

A DISCUSSION OF THE PROPOSALS

The previous chapter outlines a proposed new system for meeting the objectives of individual treatment and public safety.

Chapter V discusses these proposals in greater detail, provides additional supportive information and clarifies some of the underlying assumptions.

This chapter anticipates several questions and attempts to answer them. There are undoubtedly numerous additional questions that should be discussed and it is expected that the public will have full opportunity to engage in a discussion of the proposals through public hearings and correspondence with the Subcommittee.

1. E.S.U. EVALUATIONS

QUESTION: It has been recommended that the Emergency Service Units will perform an "evaluation." What will the evaluation consist of and which professionals will do it?

ANSWER: The evaluation should include an analysis of the citizen's medical, social, and financial problems and resources. Whenever possible the family should be involved because the symptoms of the individual often indicate a family problem. The E.S.U. evaluation will differ from current pre-commitment evaluations for the court. The effort will be to uncover the source of the problem and secure the right kind of help.

Because of the wide variety of problems that will be encountered it is important that the evaluation teams consist of various skilled professionals. The old tendency to cast all problems into a medical mold should be avoided. In this connection it may be advisable to alter the traditional professional hierarchy to reflect the nature of the multi-purpose evaluation. There is the evidence to support the effectiveness of such an approach.¹³⁸ The hard

¹³⁸"All professional personnel should have equal status, and traditional distinctions between the psychiatrist, the clinical psychologist and social worker should be ignored. The experience at Cowell and at Highland Hospital's out-patient service indicates conclusively that this is highly successful and that all members of the staff are enthusiastic about the arrangement." Lillian B. McCall and John R. Moore, "A Proposed Demonstration Project for Comprehensive Community Mental Health Services," June 24, 1963, p. 19.

facts are that there are fewer than 2,000 practicing psychiatrists in California. The majority are in private practice. Most of the remainder are in state hospitals, teaching and consultation positions, and administrative jobs in clinics and hospitals. Necessity requires that every effort be made to maximize the use of psychologists, social workers, family physicians, lawyers and other professionals. A deliberate effort must also be made by the various agencies and professional groups to resolve traditional jurisdictional disputes.¹³⁹

¹³⁹"There is a very real possibility and even higher probability that community mental health will become the captive of an outmoded professional and social hierarchy of psychiatry, psychology, and social work. The new clinics may prove to be only a freshly-sanded, yet unbloodied area in which continuing combat will take place between existing professionals. The in-fighting among the 'helping disciplines' makes it very difficult to distinguish between the friends and the enemies of our society. Yet the general public lives in a dream world in which it believes that the maturity of mental health workers allows them to rise above the petty jealousy of internal dispute over who owns mental health. The truth is that despite extended negotiations between the disciplines during the last twenty years, there is a continued and mostly secret jurisdictional dispute." Elton B. McNeil, "How Healthy Can the Great Society Be?", Trans-Action, April/March 1966, p. 32.

2. THE E.S.U. IN RURAL AREAS

QUESTION: It is suggested that the Emergency Service Units be located as "close to home as possible." How can sparsely settled rural areas develop such a comprehensive program?

ANSWER: In a state as diverse as California, flexible programming for rural areas must be the rule rather than the exception. As a recent Department of Mental Hygiene study illustrates, rural areas include desert villages both near and at great distance from large population centers, Central Valley farming regions, mountain towns, and rugged seacoast. Some of these regions may have state or private psychiatric hospitals. But others may not even have a school psychologist or an adequate number of general medical practitioners. The practical effect of this diversity is that the Department of Mental Hygiene will have to encourage pilot projects in the rural areas to learn the best ways of meeting this still unresolved problem. The following examples of pilot projects are not exclusive, and are offered to the reader as illustrations of possible alternatives. Many of the suggestions derive from the DMH study, Mental Health Services in Rural Areas.¹⁴⁰

¹⁴⁰ California, Department of Mental Hygiene, Mental Health Services for Rural Areas, A Mental Health Planning Study, August 1965.

A. In some rural areas, Mendocino and Stanislaus Counties, for example, the state hospital may be the most effective resource to provide the E.S.U. functions. These activities can be performed in the hospital or, preferably, in the patients' own community by traveling teams.¹⁴¹ E.S.U. units operated by state hospitals shall meet the same criteria and standards as other E.S.U. units, should use the same fee schedules, and should develop the same contractual arrangements with other state and local agencies to guarantee a continuity of comprehensive services.

B. Evaluation and treatment teams could be flown to rural areas. These teams could either take one or two days each week from their regular practice in a large population

¹⁴¹This approach has proven effective in a rural area in New York State:

"In 1960, Dutchess County had one of the highest patient admission rates to the state hospital in the entire State of New York. A special unit was established for all Dutchess County admissions where intensive treatment was available.

"From its inception, the unit staff set out to ascertain what proportion of the patients admitted there could be cared for by means other than full hospitalization, when a pre-diagnostic screening service was available. With the cooperation of the local medical society, the unit physicians agreed to see patients either in their homes, the hospital, or elsewhere in the community to determine whether or not hospitalization was necessary

"Under this arrangement, of the first 700 patients who received the pre-diagnostic screening, only 25 percent were admitted to the hospital for 24-hour care; 33 percent were admitted to the day hospital and 42 percent remained in the community." U.S. Dept. of Health, Education, and Welfare, The Comprehensive Community Mental Health Center, April 1964, p. 21.

center (flying, for example, from San Francisco to Modoc County each Monday); or they could be full-time teams stationed at the hub of rural service needs (in Redding, for example, and flying to Lassen, Modoc, Siskiyou, Trinity, and Del Norte Counties on a weekly five-day schedule.

C. A third possibility is to provide supplemental training to those persons in rural areas best equipped to provide mental health evaluation, counsel and treatment. This could be done by bringing social workers, public health nurses, doctors, ministers, and psychologists to a special two-week course, contracted for by the Department of Mental Hygiene, at the University of California. These people could then return to their communities better equipped to provide E.S.U. services.

An intriguing addition to this plan is the possible use of closed circuit TV for direct consultation between urban and rural specialists. A less expensive version of this approach would be an arrangement for the exchange of tape recorded interviews and suggestions.

3. THE OPEN HOSPITAL

QUESTION: Will open hospitals work and what will happen to crisis-unit patients after 14 days? Suppose people want to leave but still "need treatment?"

ANSWER: In the proposed new system, citizens will be free to decide whether they wish to enter or leave the hospitals.

This is not an innovation. Open hospitals are possible and successful. Many enlightened mental health leaders have endorsed this approach not only for civil liberties reasons but for treatment reasons as well. Dr. Robert Hunt, a New York State hospital director, comments as follows:

Much of the unnecessary crippling of the mentally ill must be laid at the door of the state mental hospital both from the standpoint of how it functions internally and how it is used by the society it serves.

. . . .

The certified mental patient in our culture is traditionally regarded as one who has lost all capacity for managing his own affairs. For his own protection and welfare and for the safety of the public, his every move must be directed and supervised. He is ordered to get out of bed, is told what clothing to put on, when and where he may smoke a cigarette. He is ordered to take part in occupational therapy, to toss a medicine ball, or watch a movie. He takes a bath at the prescribed time and under the immediate supervision of an attendant. . . . In 1792, Philippe Pinel removed the chains from the lunatics in the Bicêtre and dramatically demonstrated that

most of the mad behavior was an artifact, a reaction against the brutal methods of control imposed upon the mentally ill. In our enlightened times, most of us working in public mental hospitals have been satisfied that we were applying the lessons learned from Pinel, that at least we were not making our patients worse by medieval brutalities even though our treatment techniques left something to be desired. This smugness has been shattered by such pioneers as Macmillan and Rees who have rediscovered the values of the open hospital. Their experiences, which are now being confirmed on this side of the Atlantic, have shown beyond question that much of the aggressive, disturbed, suicidal, and regressive behavior of the mentally ill is not necessarily or inherently part of the illness as such but is very largely an artificial by-product of the way of life imposed upon them. (Emphasis added.) The virtual disappearance of antisocial and irresponsible behavior when patients are treated and trusted as responsible fellow beings is most convincing and forces us to a total re-examination of our traditional procedures. We then see that our modern standard practices may be almost as brutalizing and degrading as those which Pinel abolished. It is a rare patient in our hospitals who suffers cruelties to the flesh, but we are beginning to realize that restraints on the human spirit cannot be measured in terms of iron bars and canvas straps alone but derive much more importantly from the attitudes and expectations of the human beings around one

". . . I have no patience with those ostensibly well-meaning crusaders who place the blame for the custodial culture on such internal factors as, too few doctors, too few nurses, too little therapy, and too few dollars. A basic assumption in many reform waves seems to be that the addition of therapeutic tools and viewpoints to the mental hospital will automatically convert it from a custodial to a treatment institution This in no way alters the fact, however, that the primary function of the institutions is a custodial one for the majority of the patients.¹⁴²

¹⁴²Robert C. Hunt, M.D., "Ingredients of a Rehabilitation Program," An Approach to the Prevention of Disability from Chronic Psychoses, Proceedings of the Thirty-Fourth Annual Conference of the Milbank Memorial Fund, 1957, Part I.

In commenting on the patient who wants to leave the "open" hospital before the hospital staff believes he is "ready", Dr. Macmillan explains:

. . . I see them or the consultant sees them, and we also see the relatives. We tell them that they are not better, that we are quite sure that they will need further treatment. We tell them that we will be pleased to have them back for further treatment. They then almost invariably assure us that if they feel the need they will come back. So much of this desire to leave the hospital is the desire to make quite sure they can leave. Very often the relatives back them up in that attitude because they feel also they would like to make sure. When the patients go out and they relapse, the relatives see that it is necessary for them to come back and also they have been reassured that they can leave when they wish. Then we have the relatives on our side. They cooperate with us and that is important.

We find if we put it to the patient in that way -- that they are still sick, that they will need further help and we are willing to give it to them -- they do cooperate and come back quite freely. They are often very reassured to know that they can come back.¹⁴³

One of the most impressive and well-evaluated demonstrations of the "open hospital" program has been conducted for the past five years at Northern State Hospital, Sedro Woolley, Washington. The Superintendent, Dr. William D. Voorhees, Jr., has provided the Subcommittee with a wealth of material about this program. A few illustrative quotes have been selected to show what is being done and

¹⁴³ Ibid., p. 43

and how well it works:

In addition to emphasizing effective medical treatment, we place a great deal of importance on setting expectations about hospitalization. We convey to the patient and his family the idea that psychosis is a temporary disruption or crisis and that treatment can result in the patient's resuming and perhaps improving his typical life organization. At the time of admission, patients and relatives are routinely told that the period of hospitalization will probably be a month or less. Visiting hours are from 9 a.m. to 9 p.m. daily, and relatives, including children, are encouraged to visit frequently, with no restriction on length of visits The patient selects his own room and is reassured that his privacy will be respected. Each room has a locker where the patient may lock up his clothing and personal belongings. Staff interactions with each patient communicate belief in his ability to function appropriately and control his behavior.¹⁴⁴

- - - -

. . . For the chronically, socially incapacitated patient with many prior hospitalizations, admission to the acute treatment area of the Unit at first perplexes him, then reawakens in him the residue of long lost self-confidence. As with the hypnotic suggestion, the patient rises to meet the expectation set for him of increasing competence to make his own significant decisions in everyday living and life planning, first within the hospital, and soon without.

Supplied with a psychotherapist, patients contact him for their own appointments, and make surprisingly effective use of therapy, given only the guide lines that highest priority in the transaction should lie with planning to overcome the social or personal obstacles that had necessitated hospitalization the week before. Vacuous requests to go home are non-existent because each patient knows that this is precisely his goal and that the task of engineering it is his. In such a dormitory of "responsible" individuals, no nursing staff is required, save one

¹⁴⁴John B. Deiter, "Brief Inpatient Treatment - A Pilot Study," Mental Hospitals, February 1965, p. 2.

"desk clerk" who serves an an informational resource person. The mere presence of nursing staff signifies dependency is expected To the understandable concern of the hospital administration, patients drive the 40 miles to and from the hospital for their planned week ends home in their own automobiles without incidence (making their own decisions whether or not the side effects from medication make it unwise for them to drive.) The unquestioned free right of the mails and telephone made these mediums useless as a mechanism of acting out, or of circuitous communications to their psychotherapist.¹⁴⁵

- - - -

Our findings suggest that treatment of acute emotional disturbances requires a relatively short period of actual hospitalization. The program described handles more than 95 percent of typical psychiatric admissions to a state hospital. While it is presently being carried out in a state hospital with provision for continued care of patients in the community, there is nothing about the program that requires a large psychiatric hospital as its setting. It appears that, given a suitable physical plant, such a program could readily handle the problem of acute adult mental illness in a community setting with little recourse to longer term facilities.¹⁴⁶ (Emphasis added.)

¹⁴⁵Willard A.E. Larson, M.D. (Medical Director, Snohomish Unit, Northern State Hospital, Sedro Woolley, Washington), "The Positive Self-Fulfilling Prophecy," pp. 3-4.

¹⁴⁶John B. Deiter, op. cit., p. 5.

4. THE PROBLEM OF CONVERTING STATE HOSPITALS

QUESTION: How can California's state and community hospitals convert to "open" hospitals if they retain a "security" responsibility for some patients?

ANSWER: After July 1968 when the proposed new laws become effective, hospitals will provide completely "open" hospital services for voluntary patients or such patients will probably choose not to enter.¹⁴⁷

It is desirable that custody patients be kept in separate security hospitals. No voluntary patient should ever be moved from a voluntary program to a security program without court action. Such a move would constitute a revocation of the patient's liberty and must be done through legal proceedings.

It is expected that most state hospitals will not immediately complete the full conversion to an "open" hospital program. But this can be done gradually. As all new non-dangerous patients enter the hospital, it is recommended they be cared for in separate units under new hospital policies and by reoriented staff.

In this connection it may be useful to examine

¹⁴⁷It should be remembered that poor persons needing care will no longer be reliant on charity hospitals after July 1968.

the factors that were considered in the conversion of
Northern State Hospital:

In approaching the general goal of achieving better mental hospital services for northwest Washington, involving Northern State Hospital and its source communities, we are faced with three alternatives. The first and more prosaic plan would be a gradual repair of hospital procedure and gradual reorientation of hospital personnel at all levels with an attempt at education of the community. This is a dubious prospect, as the efforts of an already busy staff would be pitted against the viscid resistance of the large hospital and its communities.

A second alternative would be an attempt to alter significantly the hospital-community treatment situation by innovations of some single phase or some discrete aspect of treatment. However, the effects of good procedures in one phase or aspect are easily cancelled by effects of poor procedures in other phases; the institution and the community have both gross and subtle ways of thwarting changes in established procedures as they develop one at a time.

A third alternative -- attempting to effect total change by simultaneous re-examination and revision of procedures for an entire hospital and all of the communities it serves -- is indeed a task of staggering proportions.

We are projecting what we hope will be an effective compromise by designing a program which is contained within the greater hospital but sets a part of the hospital aside as autonomous. This trial treatment-readjustment unit will have patients from only one county. The program will establish treatment, readjustment, community involvement, and administrative techniques which are not subject to the traditional methods of our greater hospital. It will have its own treatment and administrative principles, a selected staff capable of implementing these principles and an adequate social separation (insulation) of its patients from the rest of the hospital.¹⁴⁸

¹⁴⁸John B. Deiter, Ph.D., et al, "Northwest Washington Hospital-Community Pilot Program," p. 4.

5. SECURITY TREATMENT FACILITIES

Both the Department of Corrections and the Department of Mental Hygiene operate facilities for mentally disordered criminal offenders.

At present criminal defendants who are not guilty by reason of insanity or who are not mentally competent to stand trial are sent to the superior court for placement in a Department of Mental Hygiene facility for custody and treatment. Some convicted misdemeanants, who may be mentally disordered, are also routed to the state hospitals via the commitment court while others serve a brief sentence in the county jail and are then released.

Convicted felons who are mentally disordered are sent to the Adult Authority where they may be placed in security treatment facilities operated by the Department of Corrections. In addition, some criminal offenders are transferred from one state agency to another for various reasons. There appears to be no documented reason for having both these agencies operating similar facilities -- nor does there seem to be any well-defined rationale for determining which mentally disordered criminal offenders should be placed in the custody of one or another agency.

QUESTION: Should the present duplication of security treatment programs be continued? Which agency -- Corrections

or Mental Hygiene -- is the best equipped to provide adequate security and treatment for mentally disordered criminal offenders?

ANSWER: In their July 1962 report, the California Special Commissions on Insanity and Criminal Offenders (composed of noted psychiatrists and legal experts) recommended that persons acquitted by reason of mental disorder be committed to a medical facility of the Department of Corrections if still dangerous. They based this conclusion on the belief that as against the Department of Mental Hygiene the Department of Corrections was "more appropriate for the custody and medical treatment of persons who have been acquitted of crime by reason of mental illness, but who are dangerous to the community if allowed to be at large."¹⁴⁹ (One additional advantage of this proposal would be to eliminate the "criminally insane" from state hospitals -- thereby accelerating the transition to "open hospitals.")

Unfortunately, there is no comparative analysis of the relative capacities of these two agencies. Additional data is required before legislative action can be suggested to determine which department can best provide

¹⁴⁹California, Board of Corrections, Special Commissions on Insanity and Criminal Offenders, Second Report, July 7, 1962, p. 37.

the necessary treatment and custody functions.¹⁵⁰

It is recommended that the Department of Corrections and the Department of Mental Hygiene join in conducting a study to determine which department is best equipped to offer secure custody and treatment to mentally disordered offenders. The results of this study should be made available to the Legislature by January 1, 1968. It is further recommended that the Assembly conduct a concurrent study of this issue.

¹⁵⁰There would appear to be no legal barrier to placing mentally disordered misdemeanants and persons incompetent to stand trial in a Department of Corrections treatment facility providing they were separated from convicted felons and received the same treatment they would otherwise receive in a Department of Mental Hygiene facility.

6. GUARDIANSHIP

QUESTION: It has been proposed that certain gravely disabled patients may require continued assistance in managing their affairs following 14 days of treatment in a crisis unit. Who are these people for whom guardianship is proposed and what kind of legal procedure will be necessary? Who will serve as guardian and what power will he have over the ward? How can a ward re-establish his legal competency?

ANSWER: As the first step in establishing guardianship, the physician who accepted responsibility for the patient on the crisis unit or the superintendent of the security treatment facility must state in writing that he believes the person to be incapable of carrying on transactions necessary to survival and otherwise providing for such basic needs as food, clothing, and shelter. This is also the standard against which the judge of the superior court must test the petition for guardianship.

The physician's statement will be transmitted to the E.S.U. investigating section which will be given ready access to all data from the crisis unit or the security treatment ward. The investigation section's first responsibility is to explore all available alternatives to guardianship. Beyond that, it is to provide a service similar to probation department evaluations in the criminal

courts. It will provide a comprehensive background report on all relevant aspects of the citizen's medical, psychiatric, financial, family, vocational and social condition giving equal weight to the potential ward's property interests and personal freedom. It will close its report with a recommendation either for or against guardianship. Should it recommend against guardianship, the investigation section should disclose any alternatives it has discovered. This report will be sent to the originating physician and to the Office of the Personal Surrogate¹⁵¹ (if the guardian is to be a public guardian) or to a relative or friend who has been interviewed by the E.S.U. investigator and who is willing to act as guardian.

The Personal Surrogate or private guardian will then petition the superior court for guardianship. The petition procedure shall follow that outlined in Probate Code Section 1435.4, and must state, with particularity, why guardianship is sought and what its terms shall be, i.e., who will control what parts of the ward's estate, where it is expected the ward will live, and which of his civil rights

¹⁵¹This title is adopted from the proposal for guardianship of the mentally retarded put forth by the Health and Welfare Agency of the State of California in October 1966. It is thought that if that proposal is enacted, the Personal Surrogate may, through separate divisions of his office, act as guardian for gravely disabled persons as well as mentally retarded. (Much of the thinking in the Health and Welfare Agency's report is incorporated in these proposals for guardianship.)

(such as the right to contract, to marry, to vote, to work, etc.) will probably need curtailment. The court will also have the report of the E.S.U. investigator available to aid in its deliberation. The ward must be present at the hearing if this is medically possible. He shall have the right to request a jury trial.

If guardianship is established, the guardian will have the powers given to him by the court decree. It is likely that decrees will vary widely in scope and in individual provisions. In fact it will be strange if they do not; for unlike civil commitment, guardianship, as contemplated in this proposal, is not a blanket device for providing custody but an individualizing function tailored to the disabilities of the ward.

The ward may institute proceedings for restoration of capacity at any time, but not to exceed once every six months. The guardian must allow funds in the estate, or public monies if the Personal Surrogate is guardian, for legal expenses entailed in proceedings to restore competency, and the burden of proof shall be on the guardian to show that guardianship is still necessary. Grounds for removal of the guardian shall be the same as those listed in Probate Code Section 1580.

The Health and Welfare Agency recommends that the Personal Surrogate be an official of state government.

Welfare and Institutions Code Sections 5075-5091 contemplate a county delegated public guardian, however.¹⁵² Additional discussion is required as to whether a state or county functionary will best fulfill the role of guardian as contemplated in these proposals.

¹⁵²"California, like a few other states, provides county Public Guardians. The services are free, but are limited to patients in certain public institutions and recipients of public assistance. Although it does not solicit guardianship, the Los Angeles Public Guardian in 1962 served approximately 1,700 persons. Most cases come either from the superior court after adjudication under Welfare and Institutions Code Section 5076 or from the Bureau of Public Assistance." Henry Weihofen, op. cit., p. 936

7. CIVIL LIBERTIES AND E.S.U. INVOLUNTARY TREATMENT

QUESTION: It has been recommended that "gravely disabled" persons, and "overtly destructive" citizens who present an immediate threat to the safety of others, may be held by the E.S.U. for 72 hours, and may even be certified for 14 days of involuntary treatment without a prior court hearing. How is this group defined and will this procedure result in a deprivation of civil liberties?

ANSWER: The primary objectives of the proposed new system are to prevent the indefinite, involuntary, and inappropriate hospitalization of non-criminal citizens, and to offer appropriate services on a voluntary basis without delay, legal disabilities or stigma. But there will be some exceptional emergency cases where the person is so disabled or so uncontrolled that they are incapable of participating in planning for their own needs. Even Dr. Thomas S. Szasz, a vocal champion of eliminating involuntary treatment agrees that some cases may require immediate involuntary care:

. . . Still another group of involuntarily hospitalized patients is composed of individuals who present so-called psychiatric emergencies. Examples are the young man who becomes uncommunicative, does not leave his room, refuses to eat, perhaps even soils himself; or the young woman who faints and thereafter remains unresponsive and acts as if she were unconscious.

Patients of this type do not object to being hospitalized or to receiving medical care.

Moreover, some of them suffer from bodily illness -- brain tumor, head injury, uncontrolled diabetes. Others develop medical problems as a result of their behavior -- severe dehydration because of failure to eat and drink, for example. Such patients should therefore be hospitalized in medical, not mental, hospitals, and should be treated as medical emergencies. Consent for hospitalization and treatment should be given by relatives, and confinement should last only until the patient has regained his powers . . .

In short, the abolition of involuntary mental hospitalization and treatment would mean that psychiatric help, like medical, would (on the whole) have to be restricted to voluntary clients.^{153, 154} (Emphasis added.)

Under the recommendations, crisis-unit treatment can only be given in high quality facilities and after a prior exploration of all alternatives. The proposed standard for 14-day detainment are as specific as a description of an incapacitated person in need of immediate treatment can be. The standard against which detainment will be tested will be whether the patient is "gravely disabled or exhibits such destructive behavior that he is an immediate

¹⁵³Thomas S. Szasz, "Mental Illness is a Myth," New York Times Magazine, June 12, 1966, p. 92.

¹⁵⁴The best estimate arising from the Subcommittee's own studies is that among all persons seen in a screening unit, such as E.S.U., about 25 percent will be classifiable as "gravely disabled", in that they will be impaired in such a way as to be incapable of caring for themselves. Among this 25 percent are a high proportion of aged senile persons, or physically debilitated alcoholics, who could be cared for in special facilities geared to meet their needs on a voluntary basis following a brief period of intensive medical care.

threat to other persons."¹⁵⁵ All persons so detained will be advised of their right to a hearing, both orally and in writing, upon admission to the crisis unit. Should they request a hearing, the doctor in charge will notify the nearest superior court immediately.

As a further check against abuse of 14-day certifications, it is proposed that copies be forwarded to the Department of Mental Hygiene for analysis and periodic reporting to the Program and Standards Board and the Legislature.

Most mental health experts agree on the importance of a crisis-unit type of approach:

DR. STAINBROOK: . . . I would like to see the

¹⁵⁵In New York under Chapter 738, Section 78 of the 1964 laws, a person alleged to be in need of immediate care, treatment or observation can be admitted to the psychiatric ward of a community or general hospital for a period of 30 days. Protesting persons so detained must be allowed a hearing within 5 days from the time of request.

According to Dr. Leonard C. Lang, Deputy Commissioner of the New York Department of Mental Hygiene, 25,000 persons were admitted to 30-day observation and treatment in this manner in the four-month period 1 April - 31 July, 1966. Of these, only 168 requested a hearing. Of those 135 resulted in retention.

Analysis of the New York system reveals that in other respects, it is not a suitable model for mental health services planning in California. New York relies heavily on its state hospitals. With a smaller total population, it has more than twice as many persons hospitalized. In a sense, they have more to undo than California does.

first two weeks of the acute psychosis dealt with as a treatment response, without just putting the patient on ice, so to speak, and waiting until he gets somewhere else, you see, because this makes psychiatry behave as though we have no acute pneumonia, and obviously we do have an acute illness.

Some of our illnesses are not only acute, but they are fatal. Yet, the fragmented aspect of this 72-hour commitment which, then, makes it mandatory for the next hospital to pick up after seven days interferes with the receiving hospital's ability to really mount a consistent therapeutic attack on the first two weeks of the illness, when I think it counts . . .

. . . I am not talking about all patients. I am talking now about acute psychotic situations where they are, by the way in which the 72-hour commitment procedures and the subsequent commitment and procedures to the state hospital are now engineered, we effectively behave as if we have no acute problem. And we are saying we are going to effectively treat this patient until he gets to the state hospital seven or eight days later, then in the state hospital, I may tell you, another two weeks may pass before they decide where he is going to go, and I think the first three or four weeks of the psychosis are tremendously important.

All I am saying is if we had more time to do an adequate handling of some of these acute cases, I think we would salvage more.¹⁵⁶

There is evidence that 14 days of involuntary care is sufficient and effective in the vast majority of cases.

One of the great pioneers of the open hospital movement, Dr. Duncan Macmillan, offers these observations about the successful Mapperly Hospital program.

¹⁵⁶California Senate Fact Finding Committee on Judiciary, Admission Care and Treatment, January 1965, pp. 47-48.

In order to get an open hospital we have removed legal certification because no hospital is really open if the patients are liable to be brought back to it by legal procedure when they leave, and no proper staff-patient relationship is possible in such a system. It causes the community to regard patients as people apart, different from other human beings. (Emphasis added.)

. . .

What we use now is a short-term compulsory stay. This is of course necessary in a definite proportion of patients. We arrange for it by an observation period of three days which can be extended by an additional fourteen days. That period fits in with the duration of acutely disturbed behavior and inaccessibility under modern conditions of treatment. (Emphasis added.) In other words, we bring the compulsory period into line with the reaction of the patients to modern treatment, and we find that they do not resent that. At the end of those seventeen days either they leave the hospital or they carry on as voluntary patients. In a very few cases we use a different form of short-term admission which authorizes a stay of four weeks, but we use that very rarely, about ten times in the first nine months of this year.

This procedure also induces therapeutic activity because we instruct the staff that it is a reflection on them if they have not gained the confidence of the patient sufficiently at the end of the seventeen days for them to carry on as voluntary patients.

During the past three years we have admitted one patient on certificate, and at the present time we have no certified patients in the hospital. . . . All the others, except for a few criminal cases who had to come in under a special procedure, were treated by this observation period . . . (Emphasis added.)¹⁵⁷

¹⁵⁷Duncan Macmillan, M.D., "Hospital-Community Relationships," An Approach to the Prevention of Disability from Chronic Psychoses, Proceedings of the Thirty - fourth Annual Conference of the Milbank Memorial Fund, 1957, Part I., pp. 35-37.

It should be noted that the old civil liberties versus treatment issues and all the related arguments are no longer applicable in discussing the proposed new system. In the proposed new system there is no long term or legal commitment of non-criminal persons, hospitals are open and legal disabilities have been removed. In other words, the main reasons for constructing elaborate and necessary legal safeguards in the past will no longer exist -- the indefinite inappropriate commitment of persons to state institutions will no longer be possible. In fact, the instrument itself, the commitment court, will no longer be needed.

8. "POTENTIALLY DANGEROUS" PERSONS

QUESTION: The proposed new system provides a mechanism for voluntary services for the non-criminal and involuntary custody and treatment of those proven dangerous. But what about people who are potentially dangerous and who may not volunteer for custody or treatment?

ANSWER: In the present commitment court system, patients may be sent indefinitely to the state hospital because they are assumed to be a danger to themselves or the person or property of others. The codes give no standard to measure "dangerousness"; thus, the determination is largely a matter of individual choice by the medical examiners.

With regard to "potentially" dangerous persons, the evidence available indicates that there are no tests that can predict an individual's capacity for dangerous behavior.

Both prisons and mental hospitals must release a certain number of persons each month or they will become overcrowded through unceasing intake. Except in the case of the prisoner whose sentence is over, the decision to hold or release is largely a matter of prediction. In theory, the prison will release only those persons who the Adult Authority feels have the most chance of successful readjustment to society. The mental hospitals will release only those who have profited from treatment. Discharge personnel working in both systems know this is theory only. The statistics bear them out.

Of 7,454 prisoners paroled from California state prisons in 1962, 46.7 percent were back in prison within two years.¹⁵⁸ This was not an unusual year. The year-in, year-out figure frequently runs closer to 50 percent. Obviously, we run quite a risk in this parole policy. Just as obviously, we have learned to live with it.

A patient either leaves a state mental hospital on indefinite leave or is discharged. Patients selected for discharge are the ones the officials feel have the best chance for success. Patients on indefinite leave are thought to be more questionable and to offer a higher risk of relapse. And yet, as one study¹⁵⁹ shows, 56 percent of both groups are reinstitutionalized within two years of release.

Thus, in two institutions where there is a long experience in the problem and where the importance of accurate prediction is keenly appreciated, the results are remarkably similar. After screening, testing and evaluation, for every two people released, one will be back in either prison or hospital within two years.

¹⁵⁸ California, Bureau of Criminal Statistics, Annual Report, 1962.

¹⁵⁹ Dorothy Miller, Robert Dickover, Setsu Gee, "A 24-Month Follow-up Study of Leave of Absence and Directly Discharged Mental Patients Released to an Urban Center, 1962-1962," Department of Mental Hygiene, Bureau of Biostatistics, (mimeograph copy), 1965.

The validity of predictions based on psychiatric testing and diagnosis is open to question. There is considerable controversy among the mental health professions on the subject of psychiatric testing and diagnosis. Until there is adequate proof of the validity of predictions about behavior it does not seem advisable to recommend legislation to confine people who may be potentially dangerous.

When a person who has committed no dangerous act is kept in a closed facility because he might be dangerous to society in the future, this is preventive jailing. We may call the facility a hospital or treatment center, but to the man locked inside it is a jail.

Preventive jailing is a dangerous technique in a free society. Even a little is probably too much in a nation which prides itself on freedom of the individual and which takes as a maxim of its criminal law that it is better a thousand guilty men go free than that one innocent be imprisoned. In short, when we deprive a man of freedom, we must be as certain as human mind and institutions allow that we act on proof that we are no longer safe with him among us.

In a study of the reliability of psychiatric predictions, Michael Hakeem cites the 1951 annual meeting of the American Psychopathological Association:

. . . Disregarding the specific authorship of the statements, it was submitted at this meeting that the concept of psychosis is not "definable" and

is so fallacious as to have "facilitated loose and unscientific thinking" in psychiatry; that the term schizophrenia means many different things to different people; that "it is hardly necessary to stress the extent to which there is confusion in regard to the diagnosis at the present time"; that because there is no agreement on psychodynamics among the different schools of thought at present, "we encounter a complete confusion" in diagnosis, that "the personality and biases of the psychiatrist may also influence his choice of a diagnostic label"; that because there is "looseness and ambiguity" in the terms used by psychiatrists, progress in diagnosis and treatment is retarded; that "the psychiatric literature is replete with dissensions and controversies" even on "elementary problems"; that diagnosis in child psychiatry "has literally been a 'Tower of Babel'"; that in the military situation, psychiatrists may deliberately make invalid diagnoses in order to comply with administrative exigencies rather than medical dictates; that the extent of agreement among psychiatrists on specific diagnoses was found through research to be "neither satisfactory nor desirable"; that an examination of researches reported in the issues of eleven psychiatric and related journals over a two-year period showed grave defects and serious lack of sophistication in experimental methodology; that psychiatric research is hampered by "an almost total lack of training in scientific disciplines."160

Appearing before the Subcommittee on Mental Health Services at San Francisco on January 18, 1966, Percy Poliak, psychiatrist, stated, ". . . the definition of mental illness is rather vague, in fact, there isn't a good definition at all. . ."

In the report of the Special Commission on Insanity and Criminal Offenders submitted to Governor Brown on July 7, 1962, the authors said:

¹⁶⁰ Michael Hakeem, "A Critique of the Psychiatric Approach to Crime and Correction," Law and Contemporary Problems, pp. 663-64.

The explanation of difficulties in this area is not far to seek. In the first place, medical knowledge of mental disorder, its characteristics, causes, and treatment is still in a relatively undeveloped state. Psychiatry is an art as well as a science, so that the working theories of modern psychiatry are the product as much of sound judgment and educated speculation as they are scientifically derived findings.

. . . Modern medical science sometimes cannot give us an unambiguous picture of the facts concerning the defendant's mental status and in no event can it provide a positive answer to the question of responsibility. Perhaps one of the chief reasons for the controversy that at times develops around the mentally ill offender is this frustrating fact. In the present state of medical science we often have to proceed on the basis of uncertain knowledge and do the best we can."¹⁶¹ (Emphasis added.)

(Four of the eleven experts on the commission were psychiatrists.)

As for the widely cited tests employed by psychiatrists such as the Rorschach and the electroencephalogram, the New York State Commissioner of Mental Hygiene has this to say:¹⁶²

"While other fields of medicine often can augment or even verify clinical diagnoses by other methods--by tests that are independent of the clinical appraisal of the patient--this is generally not true in psychiatry. Although I am fully aware of the claims that it can be done, I maintain that it cannot."

¹⁶¹ California, Board of Corrections, Special Commissions on Insanity and Criminal Offenders - First Report, July 7, 1962, p. 14.

¹⁶² Paul H. Hoch, "The Etiology and Epidemiology of Schizophrenia," American Journal of Public Health, Vol. XLVII, 1957, p. 1071.

Speaking more broadly, Dr. Leston Havens of the Harvard Medical School says:¹⁶³

. . . But the proper words to put over psychiatry's door are still not ones to quicken every pulse. For we must write there, "Accept within uncertainty or do not stay." Nothing illustrates this better than the clinical material from a schizophrenic case. We come upon broad possibilities for understanding, but as often an uncertainty that dogs our every step. . . the level of psychiatric uncertainty is above that of most medical specialties."

As for the question of diagnosing psychopathy, the aberration generally linked most closely with criminality, Hakeem's study again points up the confusion within the psychiatric profession:¹⁶⁴

Psychiatrists are in disagreement on whether they are in agreement or in disagreement on the subject. One investigator questioned seventy-five authorities, sixty-four of whom were psychiatrists, on how much agreement exists among psychiatrists on the concept of sexual psychopathy. Forty-two replied that there is no substantial agreement and twenty-four that there is. Campbell is surprised at "how much conformity exists in the minds of practicing psychiatrists concerning psychopathic personality"; Wilson and Pescor, on the other hand, say that "practically every psychiatrist has his own idea of what constitutes a psychopathic personality. . . ." Cleckley, intending to show that great unanimity exists regarding this concept, says: "If a psychiatrist, in speaking to another about a patient, uses the term psychopath, there is seldom any misunderstanding as to the sort of patient in question"; but Duval states: "Actually I am not sure whether we know what we are talking

¹⁶³Leston L. Havens, M.D., "Special Communication: Anatomy of Schizophrenia," JAMA, Vol. 196, No. 4, April 25, 1966, pp. 118-19.

¹⁶⁴Hakeem, op. cit., p. 669.

about when we speak of the psychopath. . ."

Thompson attributes the great amount of agreement among psychiatrists on the concept of psychopathy to the fact that it "is such a well-defined entity that its symptoms and characteristics are as well known to the psychiatrist as the symptoms of measles are known to the pediatrician"; but this is countered by Kennard's observation: "Clinicians do not even agree, actually, as to whether such a category exists." Overholser and Richmond express the view that "there is no general agreement among psychiatrists as to what type of personality should be designated psychopathic," only to be contradicted by Guttmacher and Weihofen, who say that while opinion about psychopathy is not unanimous, "there is considerable agreement."

Many people assume that prediction has become a precise science. In practice, this assumption takes the form of a belief that if "someone" had given the proper tests to Whitman, Speck or Oswald the tragedies connected with each of them could have been averted. Nothing in the realm of "Might Have Been" is certain. What is certain is that Whitman saw a psychiatrist shortly before his rampage, and the psychiatrist was not unduly alarmed. Speck had been in and out of prisons on a variety of lesser offenses, and none of the officials rated him a greater release risk than any other prisoner. Oswald had had psychiatric tests in the Marine Corps and these, along with considerable other data, were available to the Secret Service. The Secret Service thought he was a political eccentric, nothing more. Assuming in each case that what was known about each of these men was grounds for preventive jailing, one must also accept the concomitant of jailing tens of thousands of other men whose histories and personalities were similar. Even then, we

would not be secure for the next insane killer of public prominence may well be a quiet family man who places a bomb on an airliner.

Even if there were no scientific, ethical, or moral arguments against preventive jailing, cost alone would be prohibitive without radical readjustment of the measure of what we are willing to pay for security. In California today, we have two types of security facilities, prisons and mental hospitals. Both of these systems are chronically overpopulated, and both of them discharge people as fast as practicable. In the fiscal year 1965-66, the state mental hospitals had an average population of 27,130¹⁶⁵ mentally ill patients, and correctional facilities had 27,685¹⁶⁶ inmates. Their budgets for that year were \$184,159,355¹⁶⁷ and \$85,638,504¹⁶⁸ respectively. Together they comprised approximately 7.5 percent of the 1965-66 budget. Since 1945, the Department of Mental Hygiene has spent \$206,000,000¹⁶⁹ and Corrections \$136,000,000¹⁷⁰ on building new facilities.

¹⁶⁵Letter dated October 10, 1966, to the Assembly Reference Service from Robert T. Hewitt, M.D., Chief Deputy Director, Department of Mental Hygiene.

¹⁶⁶1965-66 Budget, p. 96.

¹⁶⁷Ibid., pp. 493-94.

¹⁶⁸Ibid., p. 95.

¹⁶⁹Hewitt, loc. cit.

¹⁷⁰Philip D. Guthrie, Information Officer, Department of Corrections.

Yearly maintenance costs per mental patient are over \$4,400.¹⁷¹
For an inmate in a correctional facility, they exceed
\$2,300¹⁷² per year. If additional people were put into either
system simply because they might be dangerous, the costs
would be fantastic.

¹⁷¹Hewitt, loc. cit.

¹⁷²1965-66 Budget, p. 97.

9. POTENTIAL SUICIDES

QUESTION: Except in instances of grave disability when 17-day involuntary treatment can be administered (72-hour hold and 14-day certification), the proposals do not provide for the involuntary treatment of persons simply because they may be dangerous to themselves (potential suicides). Why is this?

ANSWER: The proposals do include a specific recommendation for "suicide prevention services" -- a new and more effective approach than the current involuntary commitment method.

There is good evidence that to assume responsibility for preserving the life of a suicidal person may be the worst possible therapy. Dr. Willard A. E. Larson, Medical Director of a successful "open" hospital program in the State of Washington explains:

. . . the traditional nursing safeguards against suicide in the depressed person are not taken, since a responsible individual would not carry through such ill-advised behavior. We grew to realize that orthodox suicidal precautions communicate to the patient that he is untrustworthy, indeed prone to overwhelming self-destructive urges, and we give him our sanction to shed accountability for his own behavior in that we the staff are now ready to carry the full social burden of preventing his harming himself.

. . . I would like to postulate in the gravest sincerity that all in the mental health care

professions, and the well-trained psychiatrists in particular, are through longstanding medical tradition seriously underestimating the degree of responsibility that psychiatric patients will assume, and in misjudging this, grievously decimate the new patient's wavering self-esteem and self-image as a competent, self-sufficient individual, albeit a man in a crisis, and thus cause to come true in the worst, negative sense of the "self-fulfilling prophesy," the physician's fears of a dependent, irresponsible, ineffectual, and unpredictable human being possibly, if not probably, crippled for life.¹⁷³

The Emergency Service Units will provide a "suicide prevention service". Based on discussion with the staff of the Los Angeles Suicide Prevention Center, these emergency counseling and referral services appear to be effective in suicide cases. Suicide prevention services are based on the assumption "...that most persons who are acutely suicidal are so for only a relatively short period of time and that during that period, they are ambivalent about living or dying. The aim of treatment is to provide the suicidal patient with enough support during his brief contact with the Center so that he weathers the critical period and continues to live. This may require working not only with the patient but with other persons with whom he is closely involved."¹⁷⁴

¹⁷³Willard A. E. Larson, M.D., "The Positive Self-Fulfilling Prophesy," pp. 3-5.

¹⁷⁴"Emergency Psychiatric Services," California Department of Mental Hygiene, p. 30.

Even if the state were to hospitalize suicidal patients for their own protection, there is no evidence that it is possible to prevent people from killing themselves if they are determined to do so. In fact, patients in state hospitals commit suicide and patients released from state hospitals commit suicide.¹⁷⁵ Suicide is the ninth major cause of death in California. A policy of preventive custody of all potentially suicidal persons would not only fail to prevent suicides but would require a massive hospital expansion program.

Finally, it should be stated that attempted suicide is not a violation of the law in California. Therefore, any extended involuntary incarceration of a potentially suicidal person poses serious civil liberties problems. Another way of saying this is that Americans have generally

¹⁷⁵In one prominent study (Alex Pakarny, M.D., "Characteristics of Forty-four Patients Who Subsequently Committed Suicide," Archives of General Psychiatry, Vol. II, 1960, pp. 314-323, it was reported that phsyiatric patients once identified as "suicidal" patients have suicide rates five times as high as psychiatric patients generally.

It was also of interest to note that in the Subcommittee's one-day survey of state hospital residents, there were two suicides reported for the month of July among the inpatients. Further, patients who have been released on leave of absence status also have a high suicide rate, i.e., ten times greater than that of the normal California population. (See D. Miller and F. Brick, "Attempted and Completed Suicides Among Leave of Absence Patients, 1954-1964," Bureau of Social Work Administrative Report, Department of Mental Hygiene, San Francisco, unpublished monograph) 1964.

adopted the view that the state should interfere in the "unreasonable" decisions of its citizens only when those choices endanger others.

10. ALCOHOLICS

QUESTION: A sizeable number of involuntary commitments are alcoholic commitments. In the year ending June 30, 1965, 27 percent of all commitments, or 3,514 people, were involuntarily committed to mental hospitals for treatment of alcoholism. In the proposals there is no commitment court and alcoholism is not specifically mentioned. What will be done about alcoholics if the proposals are adopted?

ANSWER: Alcoholism is a major social problem. Although a great deal has been learned about the symptoms and effects of alcoholism, proven treatment methods have not yet been developed.¹⁷⁶

A great amount of private and public effort is being expended in an effort to create effective treatment programs. Both the Assembly Committee on Public Health and the Governor's Council on Alcoholic Problems are actively exploring alternatives. It is anticipated that proposals will be enacted which will complement the E.S.U. services.

The E.S.U. will of course give the same consideration to mentally disordered alcoholics as to other people.

¹⁷⁶For example, state hospital readmission rate for alcoholic patients is very high, nearly one-half return again and again to the state hospital following their first admission. Thus, while some alcoholics may be "mentally ill", current psychiatric treatment seems to make little headway in successfully dealing with the problem.

Evaluation and referral services will be offered, and voluntary inpatient and outpatient services should be as much an option for the mentally disordered alcoholic citizen as for any other citizen. Should the alcoholic be gravely disabled or threatening and unwilling or unable to seek treatment voluntarily, he can be treated on a 72-hour hold or certified to the crisis unit for 14 days maximum involuntary treatment. In general, the E.S.U. should attempt to integrate and coordinate all existing or forthcoming community services for the alcoholic with its screening and referral system. Half-way houses, family counseling, vocational training, Alcoholics Anonymous, domiciliary care, as well as medical and psychiatric care should be made available to the alcoholic.

11. CURRENT "VOLUNTARY ADMISSIONS"

QUESTION: Subcommittee investigation indicates that involuntary admission procedures satisfy neither medical nor legal standards. But voluntary admissions constitute a growing portion of present admissions. What is the state of the current law on voluntary hospitalization and how does it work in practice? Why bother to change the commitment process if voluntary admissions may continue to increase?

ANSWER: Under Welfare and Institutions Code Section 6602, the superintendent of a California state hospital may accept voluntary admissions. During the fiscal year ending June 30, 1965, 37 percent, or 8,278 persons, of all admissions to state hospitals were voluntary.¹⁷⁷ By contrast, only 23 percent were voluntary in 1960; only 15 percent in 1950.¹⁷⁸

Against this apparently satisfying growth in the use of voluntary admissions, other data provides a fuller understanding of the current situation.

¹⁷⁷Admissions of Patients by Geographic Area, County of Residence and Legal Classification; Hospitals for the Mentally Ill, Year Ending June 30, 1965, Department of Mental Hygiene, Bureau of Biostatistics, December 9, 1965.

¹⁷⁸Table 13, Admissions and Changes in Legal Classification of Patients by Legal Classification and Year of Admission, Hospitals for General Psychiatry, Years Ending June 30, 1950 through 1961; Statistical Report of the Department of Mental Hygiene, Year Ending June 30, 1961.

In the Subcommittee's one-day survey of state mental hospitals, it was found that 85 percent of the patients now in state hospitals had been committed; thus the predominant milieu is still one of involuntary custody. As other parts of this report have shown, the custodial atmosphere works against good treatment.

Despite official statements encouraging voluntary admissions¹⁷⁹ there is considerable evidence that many professionals and county officials still continue to commit patients unnecessarily. (It seems that the existence of the commitment system guarantees its use.)

"... one of the problems about commitment procedures, of course, is that their very existence perpetuates them, in the sense that if commitment procedures are possible, psychiatrists are likely, because of the tremendous pressure of time, and so on, to commit the patient rather than provide the reassuring helping relationship with the patient in which the patient's anxiety can be handled, and in getting the patient to agree to enter voluntarily."¹⁸⁰

- - - -

¹⁷⁹ "After looking at page 45 Screening the Mentally Ill Before Commitment, A Mental Health Planning Study, California Department of Mental Hygiene, December 1965/ and all the things that can happen to some mentally sick individual, it is small wonder to me that any of them survive the ordeal of commitment. How much nicer it would be if all that sort of thing could be avoided and the person entered the hospital by appearing at the door so he could be examined to determine whether hospitalization was necessary for treatment purposes." Letter from Dr. James V. Lowry, Director of the Department of Mental Hygiene to Hon. Jerome Waldie, former Chairman of the Assembly Subcommittee on Mental Health Services, April 21, 1966.

¹⁸⁰ Testimony of Dr. Edward J. Stainbrook, The Senate Fact Finding Committee on Judiciary, Admission Care and Treatment. January 1965.

" . . . the sheriff is reluctant to transport voluntary patients, he would much rather transport them while they are under court order, he feels more secure this way, and there is often no other way for them to get to the hospital than to be taken by the sheriff."181

- - - -

"MR. STOKES: . . . we are committing persons to state hospitals simply as a way of obtaining transportation for them.

CHAIRMAN WALDIE: That seems just so outrageous as to not be possible.

MR. STOKES: There is no other way of doing it. There are no community facilities . . .

CHAIRMAN WALDIE: Isn't that sad! For the rest of that man's life, because four or five dollars wasn't found, he's going to be in involuntary commitment."182

In addition there is evidence that some state hospitals prefer involuntary commitments and discourage voluntary admissions.

MR. JESS D. CANNAN: We don't use the voluntary procedure at all in our county. Now, when I say we don't use it, what I mean is that we always use the involuntary procedure; however, many of our patients are voluntary in nature but we still go through the involuntary procedures.

SENATOR GRUNSKY: What is the reason for that?

181 Testimony of Mr. Kennedy, The Senate Fact Finding Committee on Judiciary, Report and Recommendations on Commitment Procedures for the Mentally Ill, January 1965, p. 41.

182 Hearing of Assembly Interim Committee on Ways and Means Subcommittee on Mental Health Services, January 18, 1966, pp. 103-04.

MR. CANNAN: What is the reason? Well, one of the reasons is that it was my understanding, it was the understanding of our superior court judge that the hospitals preferred that. I have on occasion discussed it over the phone with them and they have said, "Well, go ahead with the involuntary procedure." They seem to prefer it.

SENATOR GRUNSKY: Well, then, why? I still would pursue the why, as to why they would prefer it, unless they have some sort of idea that the patient could walk out any time he wants to?

MR. CANNAN: That's precisely the answer.¹⁸³

- - - -

MR. GROSS: I was going to say, the statistics were surprising because I've been personally aware for some time that Agnew was not accepting voluntary alcoholics because they tend after two or three days to want to leave and made a policy, they may have changed it very recently, but it's been in force for at least the last year,¹⁸⁴ of not accepting anyone who was not committed.

A current survey¹⁸⁵ seems to indicate that the number of voluntary patients may be drawn from a specific group which is not likely to expand. The survey shows that the

¹⁸³Testimony of Mr. Jess D. Cannan, The Senate Fact Finding Committee on Judiciary, Admissions Care and Treatment, January 1965, p. 41.

¹⁸⁴Testimony of Mr. Harold Gross, Assembly Interim Committee Hearing, Subcommittee on Mental Health Services, January 18, 1966, p. 118.

¹⁸⁵John Armstrong and D. Miller, "A Follow-up Study of Voluntary Admissions: From Screening Unit to State Hospital," Study now in progress, Social Research Laboratory, Department of Mental Hygiene, San Francisco, 1966.

majority of voluntary admissions are persons who occupied a dependent relationship to a close family member and that the decision for hospitalization was made not by the patient but by the dominant family member. If the commitment system is left unchanged, this group of persons will probably continue to use the voluntary route, while others will continue to be committed.

Another problem is that state hospital voluntary admissions sometimes bypass local screening and the alternative community services that screening might lead to.

Warrington Stokes of the Alameda County Council of Social Planning, comments on this often overlooked problem:

" . . . in many instances, the hospital admits these persons but then finds that there are local community services which could have served him as well or better than the State hospital. So often these persons are admitted and very shortly are released from the hospital. . . . The hospitals are themselves saying that if these persons could be evaluated for initial diagnosis in the local service that it would then be possible for them to be served in the local community. . . ."186

Finally, "voluntary" patients are not free to leave the hospital when they choose. Under Welfare and Institutions Code Section 6602, the superintendent can hold the patient seven days after he requests to leave and move to get an involuntary commitment in the interim. This was done 272

¹⁸⁶ Transcript of Hearing of Assembly Interim Committee on Ways and Means, Subcommittee on Mental Health Services, January 18, 1966, p. 102.

times in the fiscal year ending June 30, 1966.¹⁸⁷ By contrast, a voluntary psychiatric patient can leave a public mental institution at will in most of the Canadian provinces and in Brazil, Denmark, Egypt, Finland, France, Mexico, Netherlands, Peru, Portugal, Spain, Sweden, Switzerland, Uruguay, Vietnam, and Yugoslavia.¹⁸⁸

¹⁸⁷Letter to the Subcommittee from James V. Lowry, M.D., Director of the Department of Mental Hygiene, October 14, 1966.

¹⁸⁸World Health Organization, Hospitalization of Mental Patients, France, 1955.

12. "SHORT-DOYLE" PROGRAMS

QUESTION: Since local community mental health programs (financed through the Short-Doyle formula) are expanding in California, why are the proposed changes in the commitment process necessary? Won't the rate of inappropriate hospitalizations naturally decline over a period of time if these local programs continue to expand?

ANSWER: The Short-Doyle programs have added a new dimension of service to the people of California. The proposals would build upon this base, but the Short-Doyle approach is not sufficient and cannot be relied upon to solve all the problems that have been uncovered.

First, Short-Doyle programs do not even exist in some counties.

Second, the Short-Doyle program requires 25 percent matching local funds. Some counties are unable or unwilling to make sufficiently large investments in these local programs and continue to use the commitment court as a mechanism for transferring a variety of people to state hospitals.

Third, Short-Doyle programs vary widely from one county to another in the scope of services offered and the type of persons served. It is not an equitable statewide system and although 75 percent of the supporting funds

come out of the State budget, Californians will receive very different benefits depending on where they live. For example, only 18 out of 58 counties provide local inpatient hospital services as part of their Short-Doyle programs.

Fourth, Except in those local communities where a deliberate effort has been made to use "Short-Doyle" to find alternatives to hospitalization, Short-Doyle services are often directed to different types of persons than those who are committed to state hospitals. This is not a criticism of these programs since the people they are serving may require services and may be benefiting from those services. The point is that services to certain types of persons -- however valuable -- do not reduce hospital commitments of other types of persons.

The Subcommittee survey shows that Short-Doyle inpatient facilities serve younger patients than the state mental hospitals. Sixteen percent of their patients are between 18 and 24 years of age; 43 percent are between 25 and 44 years of age. Only five percent of their patients are over 65 years of age. State mental hospital patients, on the other hand, are much older. Thirty-eight percent are between 45 and 65 years of age, while 28 percent are over 65 years of age.

One other indicator of a major difference between state hospital patients and Short-Doyle patients can be seen in the following table. Short-Doyle clinics serve a very different diagnostic group.

Diagnosis of Short-Doyle ¹⁸⁹ - State Hospital ¹⁹⁰ Patients			
Diagnosis	Short-Doyle		State Hospital
	Out-pt	In-pt	
Acute brain			
Syn.	1%	4%	1%
Chronic brain			
Syn.	2%	5%	22%
Schizophrenia	11%	21%	56%
Other psychosis	3%	4%	6%
Alcoholism	5%	27%	3%
Psycho-			
neurotic	18%	12%	2%
Personality			
Disorders	39%	23%	1%
Mental def.	1%	1%	3%
Other -			
Unknown	20%	3%	6%
Total	100%	100%	100%

There is indeed a startling and striking difference in the three populations served. Short-Doyle programs serve persons who fall largely into the minor psychiatric diagnostic categories (psychoneurosis, personality disorders), while state hospital patients are diagnosed as having more

¹⁸⁹"Major Diagnosis of Patients from Short-Doyle programs by type of service - fiscal year ending June 30th, 1965," Table #6, Department of Mental Hygiene, Bureau of Bio-Statistics, May 26, 1966.

¹⁹⁰Assembly Subcommittee one-day survey of psychiatric patients.

serious psychiatric problems (chronic brain syndrome or schizophrenia). Even the inpatient facilities provided by Short-Doyle clinics do not serve the same type of person sent to the state hospital, i.e., they serve primarily alcoholics, neurotics or personality disorder patients. (A startling finding is that whereas "schizophrenia is now considered to be treatable on an outpatient basis or with a very short period of hospitalization -- see Chapter III -- the "schizophrenic" category is the largest group hospitalized in state institutions.)

Fifth, Most Short-Doyle programs appear to be too limited in what they can actually provide for the seriously ill or dependent patient. They are often unable to provide or purchase needed community alternatives of a medical and non-medical nature and in these cases the Short-Doyle program becomes a passageway rather than an alternative to the state hospital.

For example, in counties where the Short-Doyle program is limited to outpatient services, the rate of state hospital admissions has actually increased 14.3 percent (up 58 per 100,000) during the fiscal years 1960-1965.

(This is a significant increase over counties with no services.) However, when the counties with Short-Doyle programs offer their own inpatient care, the admission rates

to state mental hospitals decreased 10.3 (down 12 per 100,000).¹⁹¹ It appears that if Short-Doyle programs are to have any effect upon state hospital admission rates, they must offer substitute care, i.e., inpatient services.

There is evidence that in many counties the Short-Doyle program is used as a mechanism to facilitate state hospital placement. For example, a recent survey¹⁹² found that 26 percent of the Short-Doyle inpatients, seven percent of the outpatients, and 12 percent of the rehabilitation patients discharged from Short-Doyle were subsequently hospitalized in the state mental hospital.

This finding is confirmed by the Subcommittee's own survey of psychiatric hospital facilities where it was found that 28 percent of the released Short-Doyle patients were sent on to the state hospital during the month of July, 1966 (For example, in a specific analysis of the releases from San Francisco General Hospital, it was found

¹⁹¹"Average Admission Rates to Hospitals for the Mentally Ill for Counties Grouped by Type of Short-Doyle Program - Years Ending June 30, 1959 and June 30, 1965." Department of Mental Hygiene, Bureau of Bio-Statistics, by Robert Beattie, Short-Doyle Analyst, May 26, 1966.

¹⁹²"Followings of Patients Discharged from Short-Doyle Programs and Subsequently Admitted to California State Hospitals for the Mentally Ill," Department of Mental Hygiene, Division of Local Programs Report, October 3, 1966.

that 51 percent of all released county hospital patients were referred on to state hospitals, while in Sacramento County 30 percent were referred on to the V.A. hospital or the state hospital for further care. Alameda County hospitals referred 35 percent of their released patients to state mental hospitals.) It appears from such statistics that somewhere between one-fourth and one-third of all persons treated at Short-Doyle inpatient facilities are referred to state institutions. Furthermore, in the Subcommittee's one-day census of psychiatric hospitals, it was found that 69 percent of state hospital patients, 97 percent of V.A. patients, 69 percent of county hospital patients, and 70 percent of private or proprietary hospital patients, and 70 percent of the convalescent hospital patients had previous psychiatric treatment. Such statistics clearly indicate that psychiatric patients are being "passed around" from one treatment facility to another, often ending in a state or V.A. facility. It also appears that once a person has been in the state hospital, he is more likely to be returned there, rather than being treated in a local facility.¹⁹³

Thus, Short-Doyle treatment facilities can become

¹⁹³D.P. Wilson, et al, "Outpatient Screening of Hospital Candidates," Mental Hygiene, Vol. XLIX, No. 3, July 1965, pp. 369-70.

✓ just one more way station for many persons en route to the state mental hospitals. They do not necessarily act to prevent state hospital admissions as can be clearly seen in the admission rates from many counties.

In summary, the Short-Doyle program provides one useful base for the development of suitable community alternatives. A few counties have used Short-Doyle to demonstrate what can be done to reduce commitments (e.g., San Mateo and Alameda) but it does not appear as if reliance on the mechanism will be sufficient. "Community Mental Health" and "Short-Doyle" are not synonymous. Rather the Short-Doyle program must be viewed in historical perspective as one early step in the proper direction.

13. MEDI-CAL FINANCING

It is recommended that citizens not now eligible for Medicare or Medi-Cal benefits be included in the Medi-Cal program for mental health services after July 1968 if the E.S.U. determines their financial and mental health condition is such as might otherwise lead to state hospitalization. This means that state funds will be used to pay for voluntary services in community facilities. This proposal suggests some changes in the state Medi-Cal program and several questions should be answered.

QUESTION: Would inclusion of people for "mental health services" draw funds away from regular Medi-Cal expenditures?

ANSWER: No. The costs would be provided by separate appropriations into the state's Health Care Deposit Fund.

QUESTION: The Medi-Cal program uses an income eligibility test which requires that citizens with incomes above a certain level pay some of the costs of their care. Should people who would have been involuntarily committed to state hospitals pay something toward the cost of voluntary treatment? Will the Medi-Cal means test cause people to reject voluntary treatment?

ANSWER: To the extent they are able, people should participate in the cost of their care. To require "mental health services" recipients to participate would merely continue the policy presently followed in existing public

mental health programs. (For example, Short Doyle programs have fee schedules, and even in state hospitals 5 percent of the patients paid the full cost and an additional 35 percent paid part of the cost in 1965.)

But the standards for payment in these existing public programs are more liberal and flexible than the state's Medi-Cal standards. The present Medi-Cal standard would impose a burden which could defeat the voluntary care concept in the commitment reform proposal. Therefore, the income standard should be liberalized to provide more reasonable standards of ability to pay for mental health services. It is recommended that the state's Health Review and Program Council examine the present Medi-Cal eligibility standard and prepare a new standard appropriate for those entering the program for "mental health services". In reviewing the standard, the Council should consider the experience in the new program of regional diagnostic centers for the mentally retarded. The Council should report its recommendations to the Legislature before January 1968. (Six months before the proposed new program would become operative.)

QUESTION: Except for those over 65, Medi-Cal financed hospital services are now limited to care in general hospitals with psychiatric wards. (Care in all other psychiatric hospitals is excluded despite the availability of hundreds of beds in these facilities.)

What services would Medi-Cal cover for "mental health

services" recipients?

ANSWER: The E.S.U. should provide citizens with access to a full range of mental health diagnostic treatment and rehabilitation services including care in licensed public and private psychiatric hospitals.

In addition, the state's Health Review and Program Council should consider extending services in private psychiatric hospitals to present Medi-Cal beneficiaries.

Many Medi-Cal eligible people under 65 who are now committed to state hospitals at 100% state expense could be cared for in private psychiatric hospitals where the total cost of care is often less than in state institutions.

¹⁹⁴As has been indicated, the Subcommittee's survey shows that the average length of hospitalization for short term (less than 90 days) patients is twice as long in state hospitals (37.7 days) as in private and proprietary hospitals (18.6 days).

In state hospitals for the mentally ill the average daily cost for all patients (of whom the majority are custodial cases) is \$11.65; (\$4,253 yearly cost divided by 365). This figure is an average and ignores estimates of intensive treatment costs for short term patients which run two to three times as high, i.e., close to \$30.00 per day.

Thus, while the per diem cost in private or proprietary facilities is generally higher than in state hospitals, the shorter length of stay results in a similar or lower total cost. For example: In Kings View Hospital, a private psychiatric hospital in Reedley, California, the costs per day were \$32.59. This includes all care, medication and nursing services -- other than psychiatric services by doctors for which an additional \$5.00 per day is charged. The average length of stay for short term patients is under 21 days. (Kings View Hospital is considered a high quality service and has recently been awarded a Community Mental Health Center grant from the federal government.)

Furthermore, overall state costs may be reduced because of the anticipated greater utilization of general hospitals (with 50% federal reimbursement) for some Medi-Cal recipients who are now cared for in state hospitals at 100% state cost. (Some small amount of these anticipated revenue gains may be lost if regular Medi-Cal recipients are permitted to utilize psychiatric hospitals where federal funds will not apply. Nevertheless, services in these facilities will be advantageous from a medical point of view and may be no more expensive or even less costly than state hospital care.)

It should also be noted that private psychiatric hospitals now have vacant beds. These unused facilities constitute a wasted resource and it is poor public policy to expand public facilities while these resources lie idle.

QUESTION: If Medi-Cal is used to enable persons requiring financial help to utilize a variety of community facilities, what implications will this proposal have for the financing of Short-Doyle programs?

ANSWER: The Short-Doyle program was developed many years before the new Medicare-Medi-Cal programs were designed and had as one of its purposes, the provisions of state and county financed community based services for those who could not afford private care. The Medicare and Medi-Cal programs have this same objective but provide

recipients a very broad range of services (not limited to Short-Doyle facilities) and will also make federal funds available to many persons.

Obviously the state should not finance the same types of services for the same persons in two different programs.

It seems logical to move in the direction of a single unified program to finance health care of lower income people. The state Medi-Cal program provides a good framework for accomplishing this objective. If the Medi-Cal program becomes the major mechanism for paying for community mental health services, it would seem appropriate (a) to permit recipients to use their Medi-Cal benefits for any E.S.U. approved service -- including, but not limited to Short-Doyle programs. Such "fees" paid to Short-Doyle agencies then could be deposited in the state's Health Care Deposit Fund to offset state and county funds allocated to Short-Doyle; or (b) if the eligibility standards for "mental health services" recipients are liberalized as has been suggested, there may be no need for separate funding of direct treatment services through the Short-Doyle formula. This alternative would permit the Short-Doyle programs to retain all fees as any other "vendor".

It is recommended that the Health Review and Program Council and the Assembly Interim Committee on Public Health study these alternatives and the feasibility of opening the

Medi-Cal program beginning July 1968 to additional people who need psychiatric care and are unable to fully pay for that care. As ingredients in that study the Council and the Public Health Committee should determine how financing would be available to sustain those activities of the Short-Doyle clinics not directly connected with patient care, if all present state and county Short-Doyle funds are placed in the Health Care Deposit Fund.

SUMMARY STATEMENT

1. "The system" (of commitment courts, state hospitals for the mentally ill, and other psychiatric institutions) is being used to carry out several very different social objectives: The system is used to secure treatment for sick people; to provide public safety from dangerous people; and to take care of a wide variety of non-medical social problems. These very different objectives are not, and cannot be, properly accomplished within a single system. The study has revealed inherent contradictions so basic as to frustrate any attempt to resolve them with minor procedural changes.
2. The concept "mental illness", is a nonscientific, generalized and popular label used to explain a wide variety of behavior. This vague concept is no longer sufficient for legislative planning purposes. The concept has produced a system of mass rather than individualized services.
3. Popular notions linking mental disorders and dangerous behavior are unjustified. Less than 10 percent of present state hospital patients are assaultive or violent. Psychiatric diagnosis and testing cannot accurately predict dangerous behavior but some persons are committed involuntarily because they are presumed--not proven--to be dangerous.
4. The commitment process and rates of commitment vary widely among the counties. Generally the commitment procedures fail to satisfy the requirements of good legal and medical practice.

As for the medical examinations and recommendations to the court, they tend to presume mental illness, be performed in a perfunctory manner, and are based on vague criteria.

As for the legal procedures, citizens are often illegally detained in poor facilities for screening; fail to receive adequate legal counsel; and are committed indefinitely in 4.7 minutes (statewide average).

5. In the majority of cases, citizens are committed because they need "treatment", not because they are dangerous. But such "treatment" as most state hospital patients receive is in overcrowded, understaffed, remote facilities. Often involuntary hospitalization harms rather than helps the committed citizen and aside from failing to solve his problems, stigmatizes him and leaves him with serious legal disabilities.
6. Many nonpsychotic aged persons are still being involuntarily committed to remote institutions in violation of state law.
7. Present "mental health counselor services and "Short-Doyle" programs attempt to provide alternatives to involuntary commitment. These programs have had some impact on inappropriate commitments in some communities. But the quantity and quality of these programs varies widely, and some of them fail to serve those most vulnerable to commitment. Even when existing screening programs suggest community alternatives to hospitalization, many of the low income people who comprise the bulk of the cases cannot afford these alternatives.

These findings point up the need for major changes in the legal and treatment system for citizens with mental disorders. The old deficient single system should be replaced with new methods. The suggested proposals are designed to align our organizational mechanisms with modern treatment techniques and sound legal practice. (Many of these new concepts were first advanced in 1962 by the Department of Mental Hygiene in A Long Range Plan for Mental Health Services in California.) The following is a very brief summary of the recommendations contained in Chapter IV:

1. The focus of California's concern for its mentally disordered citizens should be shifted from state hospitals to voluntary community services. To accomplish this redirection of emphasis, emergency service units (E.S.U.'s) should be established in each community. These units

will offer short-term intervention services including medical, psychological, social and legal evaluations; emergency counseling and suicide prevention; "priority" referrals to appropriate hospitals, clinics, or community agencies; and access to funds for the purchase of services.

2. Citizens who are gravely disabled or who exhibit such destructive behavior that they are an immediate threat to other persons may be certified for involuntary crisis treatment (with legal review procedures) not to exceed 14 days. Beyond that time they must be released to voluntary services or legal guardianship must be established.
3. No legal disability of any kind shall be incurred by citizens using E.S.U. services.
4. A multidisciplinary Program and Standards Board shall formulate policy, adopt standards, and approve contracts for emergency service units. The Department of Mental Hygiene (Division of Local Programs) will contract with various city, county, state, and private agencies to provide comprehensive E.S.U. services in each community and will administer the program.
5. Citizens who previously would have been committed to a state hospital and who are not now eligible for Medi-Cal, will be made eligible for E.S.U. and E.S.U. referral services as "mental health services" recipients. Other citizens' expenses will be met out of prepaid health policies and their own resources (on a sliding scale), Medicare, Medi-Cal, and federal "Community Mental Health Center" funds. Counties will not be expected to participate beyond their present expenditures in the operating costs of E.S.U.-type services.
6. State hospitals will be upgraded and converted to "open hospitals".
7. Mentally disordered criminal offenders shall be processed in the criminal courts which have well-developed procedures for guaranteeing community safety and protecting individual rights through due process. When mentally disordered offenders are confined it must be for treatment not punishment.

Except in a few instances where current procedures are improved to provide better protections for community safety

and greater respect for due process for the disordered offender, current criminal law remains unchanged.

The intention in the proposed new system is to guarantee that:

A citizen of California, the victim of sickness of mind or spirit, shall, without stigma or loss of liberty, receive prompt assistance to match his need.

A mentally ill citizen may be confined, and have his liberties abridged, only when proven dangerous to the community by due process of law.

APPENDIX

In the interest of keeping the report as concise as possible, extensive tables and copies of questionnaires have not been reproduced. The information contained in the Appendix has been specifically referred to in the text.

For those interested, more detailed findings and copies of questionnaires are available in a technical supplement prepared by Social Psychiatry Research Associates. This document will be available on request after January 1, 1967.

APPENDIX TABLE I

Admissions and Involuntary Commitments
To California State Hospitals:* A Ten Year Comparison

	Total Admissions (Excluding Obser- vation Cases)	Total Involuntary Commitments**	% of Admissions Committed	Rate of Admission per 100,000 Population
1955	16,322	13,534	83%	129.9
1960	20,605	15,267	74%	130.1
1965	22,189	13,612	61%	141

* Material derived from Department of Mental Hygiene, Statistical Reports, 1955 and 1960. 1965 Statistics taken from Preliminary Tabulations, Department of Mental Hygiene, Bureau of Biostatistics, December 9, 1965.

** Involuntary commitments include Mentally Ill Alcoholic, Mentally Disordered and Mentally Abnormal Sex Offender, Habit Forming and Narcotic Drug Addict Commitments.

Admissions and Involuntary Commitments to California
State Hospitals by Counties:* A Five Year Comparison

	Total Admissions (Excluding Obser- vation Cases)		Total Involuntary Commitments		% of Admissions Who Were Committed	
	1960	1965	1960	1965	1960	1965
<u>North Coast Area</u>						
Del Norte	15	20	8	9	53%	30%
Humboldt	118	156	81	61	69%	37%
Lake	12	52	8	0	67%	0%
Mendocino	153	205	90	21	59%	10%
<u>North Valley & Mountain Area</u>						
Butte	151	149	107	78	71%	53%
Colusa	17	21	12	11	71%	52%
El Dorado	35	66	22	25	63%	38%
Glenn	17	13	12	5	71%	38%
Lassen	12	16	9	10	75%	63%
Modoc	7	7	7	7	100%	100%
Nevada	39	41	21	12	54%	29%
Placer	118	90	65	19	55%	21%
Plumas	19	27	16	19	84%	70%
Sacramento	707	804	509	539	72%	67%
Shasta	62	128	45	83	73%	65%
Sierra	3	1	3	0	100%	0%
Siskiyou	32	48	22	22	69%	46%
Sutter	48	55	41	43	85%	78%
Tehama	16	37	8	10	50%	27%
Trinity	6	7	6	4	100%	57%
Yolo	100	93	71	50	71%	54%
Yuba	42	57	34	32	81%	56%
<u>Greater S. F. Bay Area</u>						
<u>S. F.-Oakland</u>						
<u>Metropolitan</u>						
Alameda	1,541	1,420	1,219	864	79%	61%
Contra Costa	546	682	447	574	82%	84%
Marin	182	233	132	128	73%	55%
San Francisco	2,624	2,652	2,416	2,072	92%	79%

*1960 Statistics taken from Admissions to State Hospitals for General Psychiatry by County, Bulletin #6, Department of Mental Hygiene, April 1961. 1965 Statistics taken from "Admissions of Patients, by Geographic Area, County of Residence and Legal Classification, Hospitals for the Mentally Ill" Year Ending June 30, 1965, Department of Mental Hygiene, Bureau of Biostatistics, December 9, 1965 (Preliminary Tabulation).

	Total Admissions (Excluding Obser- vation Cases)		Total Involuntary Commitments		% of Admissions Who Were Committed	
	1960	1965	1960	1965	1960	1965
<u>Greater S. F. Bay Area</u>						
<u>S. F.-Oakland</u>						
<u>Metro. (Cont.)</u>						
San Mateo	505	468	350	256	69%	55%
Monterey	208	231	125	150	60%	64%
Napa	199	144	122	23	61%	16%
San Benito	19	16	11	5	58%	31%
Santa Clara	1,158	1,324	690	635	60%	48%
Santa Cruz	143	127	101	97	71%	70%
Solano	243	315	163	126	67%	40%
Sonoma	214	406	127	148	59%	36%
<u>North San Joaquin Valley & Mountain Area</u>						
Alpine	-	-	-	-	-	-
Amador	12	10	6	3	50%	30%
Calaveras	7	9	3	4	43%	44%
Mono	2	2	1	0	50%	0%
San Joaquin	679	1,189	458	451	67%	38%
Stanislaus	261	465	156	159	60%	34%
Tuolumne	28	41	20	14	71%	34%
<u>South San Joaquin Valley & Mountain Area</u>						
Fresno	383	336	327	244	85%	73%
Kern	218	282	166	213	76%	76%
Kings	47	52	34	33	72%	63%
Madera	49	60	31	48	63%	80%
Mariposa	7	6	1	6	14%	0%
Merced	89	72	58	43	65%	60%
Tulare	177	171	146	121	82%	71%
<u>So. Calif. & Desert Area - Los Angeles Metro. Area</u>						
Los Angeles	5,268	6,938	3,453	4,053	66%	58%
Orange	583	845	394	577	68%	68%
Imperial	64	98	56	92	88%	94%
Inyo	16	19	12	14	75%	74%
Riverside	462	622	389	519	84%	83%
San Bernardino	1,092	1,152	873	811	80%	70%
San Diego	1,200	869	1,107	809	92%	93%
San Luis Obispo	118	48	102	37	86%	77%
Santa Barbara	187	258	148	195	79%	76%
Ventura	338	442	235	205	69%	46%
TOTAL STATE	20,601	22,189	15,267	13,618	74%	61%

APPENDIX TABLE II

California Psychiatric Hospital Patients With
Behavioral Tendencies Thought to Indicate a
Danger to Themselves or Others by Type of Facility

(PERCENTAGE)

Behavioral Tendency	V.A.	✓ State Hosp.	Co. Hosp.	Priv. Prop.	Conv. Hosp.	Total Average
Suicidal	3%	2%	18%	5%	1%	3.4%
Assaultive or Violent	10%	9%	13%	11%	11%	9.6%
Other	87%	89%	69%	84%	88%	87%
Total	100%	100%	100%	100%	100%	100%

APPENDIX TABLE III

Type of Admission of Patient Sample in Each Type
of Psychiatric Facility

(PERCENTAGE)

Type of Adm.	V.A.	State Hosp.	Co. Hosp.	Priv. & Prop. Hosp.	Conv. Hosp.
Unknown	16	2	1	1	3
Physician's Certificate	--	1	1	23	28
Commitment	37	78	9	12	17
Health Officer	--	1	--	--	--
Transfer	3	1	3	3	4
Voluntary	43	14	45	52	31
Juvenile Court	--	1	2	5	--
72 Hour	--	1	29	1	--
Other	1	1	10	3	17
TOTAL	100%	100%	100%	100%	100%
Number	384	2,448	211	824	573

APPENDIX TABLE IV

JUVENILES.

If the juvenile court, after finding that a minor is subject to its jurisdiction, is in doubt concerning the state of mental health or the mental condition of the minor, it is authorized to continue the hearing and to commit the minor to the Department of Mental Hygiene for placement in a state hospital or state home for the mentally deficient for an indeterminate period of not more than 90 days, for observation of the mental condition of the minor and recommendations concerning his future care, supervision, and treatment. (W. & I.C. Sec. 703 and W. & I.C. Sec. 5725)

ALCOHOLICS.

If it appears to the magistrate, on the basis of the affidavit, that the person is so far addicted to the intemperate use of habit-forming drugs, other than narcotic drugs, as to have lost the power of self-control, or is subject to dipsomania or inebriety, the magistrate is required to issue a warrant to a peace officer directing that the person be apprehended and taken before a judge of the superior court for a hearing and examination. The officer must then apprehend and detain the person until a hearing and examination can be had, and, at the time of apprehending the person, must serve a copy of the affidavit and warrant on him. (W. & I.C. Sec. 5400.)

NARCOTIC DRUG ADDICTS.

If the magistrate finds, on the basis of the affidavit, that the person is a narcotic drug addict, he is required to issue a warrant directing a peace officer to apprehend the person and take him before a judge of the superior court for a hearing and examination. The officer must then apprehend and detain the person until a hearing and examination can be had, and, at the time of apprehension, must serve a copy of the affidavit and warrant on the person. (W. & I.C. Sec. 5351.)

APPENDIX TABLE V
COMPARISON OF DISABILITIES RESULTING FROM MENTAL COMMITMENTS AND ADMISSIONS AND CONVICTION OF FELONY

	Involuntary Commitment to State Hospitals and other Mental Institutions	Voluntary Admissions to State Hospitals and other Mental Institutions	Conviction of Felony
Right to Vote	When a person is committed to a state hospital, the judge who orders the commitment shall issue a certificate of that fact (Elec. C., Sec. 388). If, within six months, the clerk or registrar does not receive from the hospital or court a certificate that the person has been restored to competency, the clerk or registrar must cancel the affidavit of registration of the person (Elec. C., Sec. 388.6). The person thereafter is ineligible to vote until a certificate of competency is issued and he reregisters.	No effect.	The county clerk is required, in the first week of September in each year, to examine the records of the courts having jurisdiction in felony cases, and to cancel the affidavits of registration of all voters who have been finally convicted of felonies (Elec. C., Sec. 389).
Vacancy in Public Office	An office becomes vacant upon the insanity of the incumbent, when determined by a final judgment or final order of a court of competent jurisdiction (Gov. C., Sec. 1770). When an officeholder is declared to be insane, the court is required to give notice of that fact to the officer empowered to fill the vacancy (Gov. C., Sec. 1771). (See <i>Mason v. Los Angeles</i> , 130 Cal. App. 224.)	No effect.	An office becomes vacant when the incumbent is convicted of a felony (Gov. C., Sec. 1770). When an officeholder is so convicted, the court is required to give notice of that fact to the officer empowered to fill the vacancy (Gov. C., Sec. 1771).
Right to Possess Firearms	The law provides that no person who is a mental patient in any hospital or institution shall be discharged from any hospital or institution until he has been examined by a physician or peace officer and found to be sane and capable of control (W. & I.C., Sec. 5150). Law enforcement agencies and peace officers are required to confiscate firearms in the possession of any person detained or apprehended for examination of his mental condition, and are required to retain such firearms until the release of the person without commitment, his restoration to capacity, or the appointment of a guardian for	A person who voluntarily enters a mental institution loses his right to possess firearms only while confined in the institution (W. & I. C. Secs. 5150, 5152).	It is unlawful for a person who has been convicted of a felony to own or have in his possession or under his custody or control any pistol, revolver, or other firearm capable of being concealed upon his person (Pen. C., Sec. 12021). Violation of this provision may be either a felony or misdemeanor, depending on the sentence imposed.

Involuntary Commitment to State
Hospitals and Other Mental
Institutions

the person, unless otherwise directed by a
court (W. & I.C., Sec. 5152).

Under another law, enacted in 1965, it is
made a misdemeanor for a person who has been
involuntarily committed after October 1, 1955,
to a mental institution for 30 days or more to
possess or have under his custody or control any
firearm unless he has obtained a certificate
issued by the superintendent of a state hospital
that he can do so without endangering others,
and that he has been previously confined for
30 days or more (W. & I.C., Sec. 5153).

Voluntary Admissions to State
Hospitals and Other Mental
Institutions

The commitment of a person to a mental
institution operates as an automatic suspension
of the person's license to practice certain
professions and occupations. These include prac-
tice as an accountant (B.&P.C., Sec. 5107),
as an architect (B.&P.C., Sec. 5587), as an
attorney (B.&P.C., Sec. 6007), as a barber
(B. & P.C., Sec. 6397), as a clinical labor-
atory technician (B.&P.C., Sec. 6420), as
a civil or professional engineer (B. & P.C.,
Sec. 6780), as a contractor (B. & P.C., Sec.
7124.1), as a cosmetologist (B. & P.C., Sec.
7432), as a court reporter (B.&P.C., Sec. 8030),
as a dentist (B.&P.C., Sec. 1671), as a funeral
director or embalmer (B.&P.C., Sec. 7710), as a
trainer of guide dogs for the blind (B.&P.C.,
Sec. 7211.1), as a land surveyor (B.&P.C.,
Sec. 8782), as a landscape architect (B.&P.C.,
Sec. 5674), as an optometrist (B.&P.C., Sec. 3108),
as a pharmacist (B.&P.C., Sec. 4355), as a
physician (B.&P.C., Sec. 2416), as a private in-
vestigator (B.&P.C., Sec. 7554), as a structural
pest control operator (B.&P.C., Sec. 8656), as
a vocational nurse (B.&P.C., Sec. 2879), as a
registered nurse (B.&P.C., Sec. 2763), as a
psychologist (B.&P.C., Sec. 2964), and as a
veterinarian (B.&P.C., Sec. 4884).

The voluntary admission of a person
to any mental institution operates as an
automatic suspension of his license to
practice as a barber (B. & P.C., Sec.
6597), clinical laboratory technician
(B.&P.C., Sec. 1320.2), contractor
(B. & P.C., Sec. 7124.1), cosmetologist
(B. & P.C., Sec. 7432), court reporter
(B. & P.C., Sec. 8030), funeral director
or embalmer (B. & P.C., Sec. 7710),
trainer of guide dogs for the blind,
(B. & P.C., Sec. 7211.1), landscape
architect (B.&P.C., Sec. 5674), optometrist
(B.&P.C., Sec. 3108), pharmacist (B.&P.C.,
Sec. 4355), private investigator,
(B.&P.C., Sec. 7554), structural pest con-
trol operator (B.&P.C., Sec. 8656),
vocational nurse (B.&P.C., Sec. 2879),
veterinarian (B.&P.C., Sec. 4884), physical
therapist (B.&P.C., Sec. 6189).

The voluntary admission of a person
to a mental institution operates as an
automatic suspension of his license to prac-
tice as an accountant (B.&P.C., Sec. 5107),
architect (B.&P.C., Sec. 5587), civil or
professional engineer (B.&P.C., Sec. 6780),
dentist (B.&P.C., Sec. 1671), land surveyor
(B.&P.C., Sec. 8782), physician (B.&P.C.,
Sec. 2416), and psychologist (B.&P.C.,
Sec. 2964).

Conviction of a felony is a
ground for the suspension or
revocation of a license to practice
as a clinical laboratory technician
(B. & P.C., Sec. 1320), dentist
(B. & P.C., Sec. 1679), physician
(B. & P.C., Sec. 2383), registered
dietitian (B. & P.C., Sec.
2555.1), physical therapist
(B. & P.C., Sec. 2616), registered
nurse (B. & P.C., Sec. 2761),
vocational nurse (B. & P.C., Sec.
2878), psychologist (B. & P.C.,
Sec. 2960), optometrist (B. & P.C.,
Sec. 3094), pharmacist (B. & P.C.,
Sec. 4354), psychiatric technician
(B. & P.C., Sec. 4521), veterinarian
(B. & P.C., Sec. 4882), accountant
(B. & P.C., Sec. 5100), architect
(B. & P.C., Sec. 5587), landscape
architect (B. & P.C., Sec. 6101),
attorney (B. & P.C., Sec. 6101),
civil or professional engineer
(B. & P.C., Sec. 6775), contractor
(B. & P.C., Sec. 7123), trainer of
guide dogs for the blind (B. & P.C.,
Sec. 7211.9), private investigator
(B. & P.C., Sec. 7551), court
reporter (B. & P.C., Sec. 8025),
structural pest control operator

State Licenses (cont'd)	Involuntary Commitment to State Hospitals or other Mental Institutions	Voluntary Admissions to State Hospitals and other Mental Institutions	Conviction of Felony
	Suspension of a license is discretionary with the licensing board in the case of mineral, oil, and gas brokers (B&P.C., Sec. 10562.6), real estate brokers (B&P.C., Sec. 10177.6), registered social workers (B&P.C., Sec. 9028) and yacht and ship brokers (B&P.C., Sec. 8958).	In the case of a registered nurse, a voluntary admission has no effect unless the nurse, after having admitted herself, leaves the hospital against the medical advice of a physician in the hospital (B&P.C., Sec. 2763).	(B&P.C., Sec. 8649), land surveyor (B&P.C., Sec. 8780), yacht and ship broker (B&P.C., Sec. 8955) dry cleaner (B&P.C., Sec. 9540.3), cemetery broker (B. & P.C., Sec. 9727), real estate broker (B. & P.C., Sec. 10177), mineral, oil, and gas broker (B. & P.C., Sec. 10562), and marriage counselor (B. & P.C., Sec. 17820).
Custody of Children	An action may be brought for the purpose of having any person under the age of 21 years declared free from the custody and control of his parent, if the parent has been declared by a court of competent jurisdiction to be mentally deficient or mentally ill, and if the Director of Mental Hygiene and the superintendent of the state hospital of which such parent is a patient certify that the parent will not be capable of supporting or controlling the child in a proper manner. A licensed adoption agency is authorized to institute such an action when the agency is engaged in an adoption, and the action agency, the county counsel, if there is one, or the district attorney, is required to institute the action. (Civ. C., Sec. 232, subd. (f))	No effect.	An action may be brought for the purpose of having any person under the age of 21 years declared free from the custody and control of his parent, if the parent has been deprived of his civil rights due to the conviction of a felony, if the felony is of such nature as to prove the unfitness of the parent to have the future custody and control of the child, or if any term of sentence of the parent is of such length that the child will be deprived of a substantial portion of the period of years (Civ. C., Sec. 232, subd. (d)).
Driver's License	The Department of Motor Vehicles is directed not to issue or renew a driver's license to any person who is insane or feeble-minded or an idiot or imbecile, and may revoke a driver's license previously issued to such person (Veh. C., Secs. 12805, 13359).	Same	There is no general provision calling for the suspension or revocation of a driver's license on conviction of a felony. Suspension or revocation is authorized or required in certain situations involving traffic violations, such as drunk driving, reckless driving, and others (see Veh. C., Secs. 13201, 13350).

Driver's License (cont'd)	Involuntary Commitment to State Hospitals and other Mental Institutions	Voluntary Admissions to State Hospitals and other Mental Institutions	(See previous page)	Conviction of Felony
Intoxicating liquor	in operating a motor vehicle upon the highway shall not prevent the issuance of a license to the applicant (Veh. C., Sec. 12506). It is a misdemeanor for any person to sell or furnish, or cause to be sold or furnished, intoxicating liquor to any person who has been adjudged legally incompetent or insane by any court of this state and has not been restored to legal capacity, if the seller knows such person to have been so adjudged (Pen. C., Sec. 397).	No effect.	No effect.	Conviction of a felony is a ground for dismissal of teacher (Ed. C. Sec. 13403). It is also a ground for dismissal of a state college employee (Ed. C., Sec. 24306).
Teacher's Credential	A teacher may be dismissed on the ground that his physical or mental condition makes him unfit to teach or that he is incompetent (Ed. C., Sec. 13403). It is further provided, however, that no teacher shall be suspended on a charge of incompetency due to mental disability unless the governing board has appointed a recognized psychiatrist to examine him, nor unless the psychiatrist reports in writing to the governing board that the employee is, in his opinion, suffering from mental disability of such character as to render him incompetent to perform his duties. The teacher is entitled to be represented at the examination by a psychiatrist of his own selection. The teacher has the right to receive a complete copy of all reports made by the psychiatrist appointed by the governing board (Ed. C., Sec. 13411). It will be seen, therefore, that while a commitment might lead to the institution of proceedings to dismiss a teacher, the commitment alone would not be a sufficient basis for the dismissal. The opinion of a psychiatrist would also be required.	Same.		

	Involuntary Commitment to State Hospitals and other Mental Institutions	Voluntary Admissions to State Hospitals and other Mental Institutions	Conviction of Felony
Marriage License	A marriage license may not be issued if either party is insane or an imbecile. The clerk is authorized to examine the parties, under oath, to determine whether they meet the requirements for the issuance of a marriage license. (Civ. C., Sec. 63)	Same	No effect.
Annulment	A marriage may be annulled if either party was of unsound mind at the time the marriage is contracted (Civ. C., Sec. 82).	Same	No effect.
Divorce	Incurable insanity is a ground for divorce (Civ. C., Sec. 92). However, in order for a divorce to be granted on the ground of incurable insanity, it must be shown that the insane spouse has been incurably insane for a continuous period of three years and has been confined to a mental institution, or under the jurisdiction of the institution, for at least three consecutive years immediately preceding the filing of the action and upon the testimony of a member of the medical staff of the institution that the spouse is incurably insane (Civ. C., Sec. 108). Furthermore, a court has held that a husband was not entitled to a divorce for the alleged incurable insanity of his wife where it appeared that she entered a state hospital as a voluntary patient on a voluntary basis. The court indicated that the confinement must be under court order (<i>Ruggles v. Ruggles</i> , 139 Cal. App. 2d 712).	No effect.	Conviction of a felony is a ground for divorce (Civ. C., Sec. 92).
Removal as Director of Corporation	The board of directors of a corporation is authorized to remove any director who is declared to be of unsound mind by an order of court (Corp. C., Sec. 807).	No effect.	The board of directors of a corporation is authorized to remove any director who is finally convicted of a felony (Corp. C., Sec. 807).

	Involuntary Commitment to State Hospitals or other Mental Institutions	Voluntary Admissions to State Hospitals and other Mental Institutions	Conviction of Felony
Dissolution of Partnership	On application by or for a partner, a court is required to issue a decree dissolving a partnership whenever a partner has been declared a lunatic in any judicial proceeding or is shown to be of unsound mind (Corp. C., Sec. 15032).	No effect.	No effect.
Steril- ization	The Department of Mental Hygiene, under certain conditions may cause a patient in a state hospital to be sterilized if he is afflicted with or suffering from any of the following mental abnormalities: (a) Mental disease which may have been inherited and is likely to be transmitted to descendants. (b) Mental deficiency, in any of its various grades. (c) Marked departures from normal mentality. Before the Director of Mental Hygiene may order the sterilization to be performed, he must notify the patient and his known parents, spouse, adult children, or guardian. If the patient has no known parents, spouse, adult children, or guardian, the director must notify the person who petitioned for the patient's commitment. If written consent is given, or if no objection is filed within 30 days, the director may grant authorization for the sterilization to proceed. If a written objection is filed within 30 days by the patient, his spouse, next of kin, or guardian, or the petitioner, if the patient has no next of kin or guardian, the director must hold a hearing on the matter. If he decides to authorize the sterilization, the patient or other persons previously mentioned must be given 30 days in which to file a petition in court to halt the sterilization. If no petition is filed, or if the court authorizes the sterilization, the director is free to proceed. (W. & I.C.Sec. 6624).	No comparable provision.	No comparable provision.

Involuntary Commitment to State Hospitals or other Mental Institutions	Voluntary Admissions to State Hospitals and other Mental Institutions	Conviction of Felony
Right to Contract, convey property, etc. Section 40 of the Civil Code provides that after his incapacity has been judicially determined, a person of unsound mind can make no conveyance or other contract, nor delegate any power or waive any right, until his restoration to capacity. It has been held, however, that commitment as a mentally ill or mentally deficient person is not equivalent to a judicial declaration of incapacity contemplated by this section, and, therefore, does not conclusively establish a committed person's incapacity to contract or convey property (Garroll v. Garroll, 16 Cal. 2d 761; In re Garroll's Guardianship, 149 Cal. App. 2d 294). A patient who loses the right to contract or convey property, he must be judicially declared to be incompetent under applicable provisions of the Probate Code (Prob. C., Secs. 1460-1462).	No comparable provision.	A sentence of imprisonment in a state prison for any term less than life suspends all civil rights of the person so sentenced, and extends to all public offices and all private trusts, authority or power during such imprisonment. However, the Adult Authority may restore to such a person during his imprisonment such civil rights as it deems proper, except the right to act as a trustee, hold public office, exercise the privilege of an elector, or give a general power of attorney (Pen. C., Sec. 2600).
Public Assistance It should be noted that the law gives to the Department of Mental Hygiene certain powers to protect and conserve the property of patients in state hospitals. The Department is authorized to apply for appointment as guardian of the estate of a patient who has no guardian (W. & I.C., Sec. 6600). If a patient does not have guardian of his estate, property which he has given over to the Department may be removed to a place of safekeeping. If the superintendent of the hospital determines that the patient is incurably insane or is likely to remain in a state institution indefinitely, the property may be sold at public auction and the proceeds applied in reimbursement of the expenses so incurred, with any balance to be deposited to the patient's credit (W. & I.C., Sec. 6660.5). The department may collect debts owing to a patient, if he has no guardian (W. & I.C., Sec. 6661). A person, under 65 years of age, is ineligible for public assistance so long as he is confined in a mental institution (W. & I.C., Secs. 12532, 13950, 14053).	No comparable provisions.	The law also provides that a person convicted of a felony may not serve as a peace officer (Gov. C., Sec. 1029), and makes conviction of a felony a ground for revoking a person's commission to act as a notary public (Gov. C., Sec. 8214.1).

BIBLIOGRAPHY

PUBLIC DOCUMENTS

- California. Assembly, Interim Committee on Social Welfare, Hearing on Modesto State Hospital. September 19, 1956.
- California. Assembly, Interim Committee on Ways and Means. Edited Transcript of the Hearing of the Subcommittee on Mental Health. San Francisco, October 22, 1963.
- California. Assembly, Interim Committee on Ways and Means. Edited Transcript of Hearing of the Subcommittee on Mental Health. December 20, 1965.
- California. Assembly, Interim Committee on Ways and Means. Edited Transcript of the Hearing of the Subcommittee on Mental Health. January 18, 1966.
- California. Assembly, Interim Committee on Ways and Means. Special Report on The Long Range Plan for Mental Health Service in California. January 7, 1963.
- California. Assembly, Interim Committee on Ways and Means. A Summary Report on Health Care Services for the Aged. 1965.
- California. Board of Corrections, Special Commissions on Insanity and Criminal Offenders. First Report. July 7, 1962.
- California. Board of Corrections, Special Commissions on Insanity and Criminal Offenders. Second Report, November 15, 1962.
- California. Department of Mental Hygiene. California's Community Mental Health Services Act - The Short-Doyle Act. May, 1962.
- California. Department of Mental Hygiene. Community Mental Health Centers. November 6, 1963.
- California. Department of Mental Hygiene. Emergency Psychiatric Services - A Mental Health Planning Study. December, 1965.
- California. Department of Mental Hygiene. A Long Range Plan for Mental Health Services in California. March, 1962.
- California. Department of Mental Hygiene. Mental Health Services for Rural Areas - A Mental Health Planning Study. August, 1964.
- California. Department of Mental Hygiene. A Pattern of Community Mental Health Services, Development Plan for Mental Health Services in the San Gabriel Valley, Los Angeles Metropolitan Area, 1965-1975. October, 1965.
- California. Department of Mental Hygiene. State Hospital Geriatric Problem. January 18, 1963.
- California. Department of Mental Hygiene Statistical Report. Admissions and Changes in Legal Classification of Patients by Legal Classification and Year of Admission, Hospitals for General Psychiatry, Years Ending June 30, 1950 - June 30, 1961.

Bibliography Continued

- California. Department of Mental Hygiene, Bureau of Biostatistics. Admissions of Patients by Geographic Area, County of Residence and Legal Classification Hospital for the Mentally Ill, Year Ending June 30, 1965.
- California. Department of Mental Hygiene, Bureau of Biostatistics. Average Admissions Rates to Hospitals for the Mentally Ill for Counties Grouped by Type of Short - Doyle Program - Years Ending June 30, 1959 - June 30, 1965. By Richard Beattie, Short - Doyle Analyst, May 26, 1966.
- California. Department of Mental Hygiene, Bureau of Biostatistics. Are Post Hospital Mental Patients Dangerous to Themselves and Others? A Survey of Released State Patients. By Dorothy Miller and Setsu Gee. (Unpublished report) October 1965.
- California. Department of Mental Hygiene, Bureau of Biostatistics. Major Diagnosis of Patients from Short-Doyle Programs by Type of Service: Fiscal Year Ending June 30, 1965. May 26, 1966.
- California. Department of Mental Hygiene, Bureau of Biostatistics. A 24-Month Follow-up Study of Leave of Absence and Directly Discharged Mental Patients Released to an Urban Center, 1962-1964. By Dorothy Miller, et al. (unpublished report) January, 1965.
- California. Department of Mental Hygiene, Bureau of Research. Worlds That Fail: Part I - Retrospective analysis of Mental Patients' Careers. By Dorothy Miller. September 1964.
- California. Department of Mental Hygiene, Bureau of Research. Worlds That Fail: Part II - Disbanded Worlds: A Study of Returns to the Mental Hospital. By Dorothy Miller and William Dawson, M.S.W. 1965.
- California. Department of Mental Hygiene, Bureau of Social Work Administrative Report. Attempted Suicide Among Leave of Absence Patients, 1954 - 1964. By Dorothy Miller, San Francisco, 1964. (unpublished monograph)
- California. Department of Mental Hygiene, Bureau of Social Work. One Year Longitudinal Study of State Mental Patients Released on Leave of Absence: I - Outcome Categories. By Dorothy Miller. 1964.
- California. Department of Mental Hygiene, Division of Local Programs Report. Follow-ups of Patients Discharged from Short-Doyle Programs and Subsequently Admitted to California State Hospitals for the Mentally Ill. October 3, 1966.
- California. Department of Mental Hygiene, Office of Planning. Screening the Mentally Ill Before Court Commitment - A Mental Health Planning Study. December, 1965.
- California. Department of Mental Hygiene, Office of Program Review. Project No. 7 - Review of Apparently Successful Operation of Hospital Business Administration Services. December 30, 1965.

Bibliography Continued

- California. Department of Mental Hygiene, Office of Program Review. Project No. 9 - Study of Turnover and Dropout Problem Among Psychiatric Technician Trainees in California. June 1965.
- California. Department of Mental Hygiene, Office of Program Review. Project No. 11 - Management of Services to Mentally Ill Convalescent Leave Patients: Study Site No. 1. August 1, 1966.
- California. Department of Mental Hygiene, Office of Program Review. Project No. 12 - Review of Psychiatric Residency Training Program, Metropolitan State Hospital. August 9, 1965.
- California. Department of Public Health. Hospital Licensing Act and Requirements for All Hospitals, Maternity Homes, Tuberculosis, Nursing Homes, Nursing and Convalescent Homes. April 30, 1966.
- California. Health, Education and Welfare Agency. Guardianship. October, 1966.
- California. Office of the Legislative Counsel. Various reports compiled for the Subcommittee on Mental Health on the subject of commitments of the mentally ill. 1966.
- California. Senate, Fact Finding Committee on Judiciary. Admission Care and Treatment. A report by the Subcommittee on Commitment Procedures. January, 1965.
- California. Senate Fact Finding Committee on Judiciary. Commitment Procedures for the Mentally Ill. Report and recommendations by the Subcommittee on Commitment Procedures. January, 1965.
- New Jersey. Department of Institutions and Agencies. Report of Planning - Comprehensive Mental Health Services in New Jersey. 1963-1965.
- U.N. World Health Organization. Hospitalization of Mental Patients. France, 1955.
- U.S. Department of Health, Education and Welfare. The Comprehensive Community Mental Health Center. April, 1964.
- U.S. President, 1960-1963 (Kennedy). Message From the President of the United States Relative to Mental Illness and Mental Retardation. February 5, 1963.
- U.S. Public Health Service. Community Mental Health Services in Northern Europe. No. 1407, 1965.
- U.S. Public Health Service. The Relationship Between Selected Social and Demographic Characteristics of Hospitalized Mental Patients and the Outcome of Hospitalization. Washington, D.C.: American University, June 1964. ----- Reprint. (n.d.).
- U.S. Senate, Committee on the Judiciary. Constitutional Rights of the Mentally Ill. Hearings before the Subcommittee on Constitutional Rights. Part 1, 87th Cong., 1961.
- Washington. Department of Institutions, Northern State Hospital Pilot Program. Various Reports compiled by John B. Deiter; B. J. Olson and J. A. Polander; Walter Gove; Beverly Olson and John E. Lubach; Dana B. Hanford and John E. Lubach. Sedro Woolley, Washington.

Bibliography Continued

CASES

- Olmstead v. Unites States. 277 U.S. 438, 479 (1928).
- Rouse v. Cameron. Court of Appeals, District of Columbia. (October 10, 1966). (not yet reported)

BOOKS

- Brill, Norman Q., M.D., and Hugh A. Storrow, M.D. "Social Class and Psychiatric Treatment." In Mental Health of the Poor, Frank Riessman, et al. (ed). New York: The Free Press of Glencoe, 1964, pp. 68-75.
- Ginzberg, Eli, et al. The Ineffective Soldier. New York: Columbia University Press, 1959.
- Goffman, Erving. Asylums. New York: Doubleday and Company, Inc., 1961.
- Goffman, Erving. Stigma. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1963.
- Gursslin, Orville R., et al. "Social Class and the Mental Health Movement." Mental Health of the Poor, Frank Riessman, et al. (ed). New York: The Free Press of Glencoe, 1964, pp. 57-67.
- Jackson, Don D., M.D. "Theories of Suicide," In Schneidman, E.S. and N.L. Farberow. Clues to Suicide. London: Blakiston Division, McGraw-Hill, 1957, pp. 11-21.
- Laing, R.D., and A. Esterson. Sanity, Madness and the Family. Vol I: Families of Schizophrenics. London: Tavistock Publications, 1964.
- Meehl, Paul E. Clinical versus Statistical Prediction. Minneapolis: University of Minnesota Press, 1954.
- Miller, S.M., and Elliot G. Mishler. "Social Class, Mental Illness, and American Psychiatry: An Expository Review." In Mental Health of the Poor, Frank Riessman, et al. (ed). The Free Press of Glencoe, 1964, pp. 16-36.
- Offer, Daniel, and Melvin Sabshin. "The Four Perspectives of Normality: A Synthesis." In Their Normality - Theoretical and Clinical Concepts of Mental Health. New York and London: Basic Books, Inc., 1966, pp. 97-112.
- Scheff, Thomas J. Being Mentally Ill - A Sociological Theory. Chicago: Aldine Publishing Company, 1966.
- Smith, M. Brewster, Ph. D. and Nicholas Hobbs, Ph. D. The Community and the Community Mental Health Center. Washington D.C.: American Psychological Association, Inc., June 1966.
- Special Committee to Study Commitment Procedures of the Association of the Bar of the City of New York. Mental Illness and Due Process: Report and Recommendations on Admission to Mental Hospitals Under New York Law. Ithaca, New York: Cornell University Press, 1962.

Bibliography Continued

ARTICLES AND PERIODICALS

- Bateson, Gregory and Don D. Jackson, M.D. "Some Varieties of Pathogenic Organization," Disorders of Communication, XLII (1964), pp. 270-290.-----Reprint. (n.p., n.d.)
- Birnbaum, Morton, LL.B., M.D. "Some Comments on 'The Right to Treatment'," Archives of General Psychiatry, XIII (July 1965), pp. 38-45.
- Birnbaum, Morton, LL.B., M.D. "The Right to Treatment," American Bar Association Journal, XLVI (May 1960), p. 499.
- "Civil Commitment of the Mentally Ill: Theories and Procedures," Harvard Law Review, LXXIX (April 1966), pp. 1288-1298.
- Cohen, Fred. "The Function of the Attorney and the Commitment of the Mentally Ill," Texas Law Review, XLIV, No. 3 (February 1966), pp. 424-469.
- Deiter, John B., et al. "Brief Inpatient Treatment: A Pilot Study," Mental Hospitals, XVI (February 1965), pp. 95-98.
- Eagle, Edward, Ph.D. "Charges, Costs, and Other Factors Related to Maintenance of Patients in Public Mental Hospitals," Public Health Reports, LXXVIII, No. 9 (September 1963), pp. 775-790, Washington, D.C.
- Freeman, H., and L.H. Cohen. "How Dangerous to the Community are State Hospital Patients?," Connecticut State Medical Journal, IX (September 1945), pp. 697-700.
- Forstenzer, Hyman M. "New York's New Directions in Mental Health Services," State Government, published by The Council of State Governments, XXXVII, No. 4 (Autumn 1964), pp. 235-241.-----Reprint. (n.p., n.d.)
- Fry, William F., Jr., M.D. "Marital Context of an Anxiety Syndrome," Family Process, I, No. 2 (September 1962).-----Reprint. (n.p., n.d.)
- Glass, Robert J., et al. "The Current Status of Army Psychiatry," American Journal of Psychiatry, CXVII (February 1961), pp. 673-683.
- Goertzel, Victor, Ph.D. "Research Psychologist, Camarillo State Hospital. "Voluntary and Court Committed Patients," California Mental Health Research Digest, I, No. 4 (Autumn 1963), pp. 25-32.
- Guze, S.B., "A Study of Recidivism Based Upon a Follow-up of 217 Consecutive Criminals," The Journal of Nervous and Mental Disease, CXXXVIII, No. 6 (June 1964), pp. 575-580.
- Hakeem, Michael, "A Critique of the Psychiatric Approach to Crime and Correction," Law and Contemporary Problems, XXIII (Autumn 1958), pp. 650-682.
- Haley, Jay. "The Art of Being Schizophrenic," voices. Vol. I: The Art and Science of Psychotherapy, I, No. 2

Bibliography Continued

- (Fall 1965).
- Halleck, Seymour L. "A Critique of Current Psychiatric Roles in the Legal Process," Wisconsin Law Review, MLXVI, No. 2 (Spring 1966), pp. 379-401.-----Reprint. (Law and Society, n.p., n.d.)
 - Hastings, D.W. "Follow-up Results in Psychiatric Illness," American Journal of Psychiatry, CXIV (June 1958) pp. 1057-1066.
 - Havens, Leston L., M.D. "Special Communication, Anatomy of Schizophrenia," Journal of American Medical Association, CXCVI, No. 4 (April 25, 1966), pp. 325-331.
 - Hoch, Paul H. "The Etiology and Epidemiology of Schizophrenia," American Journal of Public Health, XLVII (1957), p. 1071.
 - Hunt, Robert C., M.D. "Ingredients of a Rehabilitation Program," Proceedings of the Thirty-fourth Annual Conference of the Milbank Memorial Fund. Part I, 1957.
 - Jackson, Don D., "Action for Mental Illness -- What Kind?", Stanford Medical Bulletin, XX, No. 2 (May 1962), pp. 77-80.-----Reprint. (n.p., n.d.)
 - Jackson, Don D., M.D. "Family Homeostasis and the Physician," California Medicine, CIII (October 1965), pp. 239-242.
 - Jackson, Don D., M.D. "Family Interaction, Family Homeostasis, and Some Implications for Conjoint Family Therapy," Science and Psychoanalysis, II (1959), pp. 112-141.
 - Jackson, Don D., and John J. Weakland. "Conjoint Family Therapy: Some Considerations on Theory, Technique, and Results," Journal for the Study of Interpersonal Processes, XXIV, No. 2, Supplement (May 1961), pp. 30-45.-----Reprint. (n.p., n.d.)
 - Jackson, Don D., M.D., and Irvin Yalom, M.D. "Family Homeostasis and Patient Change," Current Psychiatric Therapies, IV (1964), pp. 155-165.-----Reprint. (n.p., n.d.)
 - Kutner, Luis, "The Illusion of Due Process in Commitment Proceedings," Northwestern University Law Review, LVII (September-October 1962), pp. 383-399.
 - Macmillan, Duncan, M.D. "Hospital-Community Relationships," Proceedings of the Thirty-fourth Annual Conference of the Milbank Memorial Fund. Part I, 1957.
 - Mental Health Progress. Published by the California Department of Mental Hygiene, VI, No. 10 (December 1965).
 - Miller, Dorothy, M.A., and William H. Dawson. "Effects of Stigma on Re-Employment of Ex-Mental Patients," Mental Hygiene, XLIX, No. 2 (April, 1965), pp. 385-390.-----Reprint (n.p., n.d.)
 - Miller, Dorothy, and Michael Schwartz, B.A. "Chronic Leave Patients: Passengers on the Hospital-Community Shuttlebus," Mental Hygiene, XLIX, No. 3 (July 1965), pp. 385-390. -----Reprint (n.p., n.d.)

Bibliography Continued

- Miller, Dorothy, and Michael Schwartz. "County Lunacy Commission Hearings: Some Observations of Commitments to a State Mental Hospital," Social Problems, XIV, No. 1 (Summer 1966), pp. 26-35. ----- Reprint. (n.p., n.d.).
- Minnesota Guardianship," Minnesota Law Review, XLIX (1965). pp. 877-887.
- Pakarny, Alex, M.D. "Characteristics of 44 Patients Who Subsequently Committed Suicide," Archives of General Psychiatry, II (1960), pp. 314-323.
- Pasamanick, Benjamin, et al. "Home vs. Hospital Care for Schizophrenics," American Medical Association Journal, CLXXVII (January 18, 1964), pp. 177-181.
- Perlman, David, "Dreary and Inhuman Crisis at San Francisco General," San Francisco Chronicle, October 11, 1965.
- Pittman, Frank S., III, M.D., et al. "Family Therapy as an Alternative to Psychiatric Hospitalization," Psychiatric Research Report, American Psychiatric Association, No. 20 (February 1966). pp. 188-195 ----- Reprint. (n.p., n.d.).
- Pugh, Thomas F., M.D. "The Population Explosion and the Future Number of Mental Hospital Inpatients," The New England Journal of Medicine, CCLXX.(September 24, 1964), p. 672.
- Rapaport, J. R., et al. "Evaluation and Follow-up of State Hospital Patients Who Had Sanity Hearings," American Journal of Psychiatry, CXVIII (June, 1962), pp. 1078-1086.
- Roemer, Ruth, LL.B. "Mental Health Legislation Affecting Patient Care," American Journal of Public Health, LII, No. 4 (April, 1962), pp. 592-599 ----- Reprint.
- Ross, Hugh A. "Hospitalization of the Voluntary Mental Patient," Michigan Law Review, LIII, No. 3 (January, 1955), pp. 353-392.
- Roth, Julius A. "The Public Hospital: Refuge For Damaged Humans," Transaction, III (July/August, 1966), pp. 25-29.
- Scheff, Thomas F. "Preferred Errors in Diagnosis," Medical Care, II, No. 3 (July-September, 1964), pp. 166-172. ----- Off print, by Pitman Medical Publishing Company, Ltd. (n.p., n.d.).
- Scheff, Thomas J. "The Societal Reaction to Deviance: Ascriptive Elements in the Psychiatric Screening of Mental Patients in a Midwestern State," Social Problems, XI, No. 4 (Spring, 1964), pp. 401-413. ----- Reprint. (n.p., n.d.).
- Segal, Henry A., "Iatrogenic Disease in Soldiers," U.S. Armed Forces Medical Journal, IV. No. 1 (January, 1953), pp. 49-59.
- Sheeley, William. "Protecting the State Hospital Function," Mental Hospitals, X (October, 1959), p. 28.

Bibliography Continued

- Singer, Margaret Thaler, Ph.D., and Lynne C. Wynne. "Thought Disorder and Family Relations of Schizophrenics," Archives of General Psychiatry, XII (February, 1965), pp. 201-212.
- Szasz, Thomas S. "Mental Illness is a Myth," New York Times Magazine, June 12, 1966.
- Terrill, James M., Ph.D., and Ruth E. Terrill. "A Method for Studying Family Communication," Family Process, IV, No. 2 (September 1965), pp. 259-290.-----Reprint. (n.p., n.d.)
- Weihs, Henry. "Mental Health Services for the Poor," University of California Law Review, LIV, No. 2 (May 1966), pp. 921-944.
- Wilson, D.P., et al. "Outpatient Screening of Hospital Candidates," Mental Hygiene, XLIX, No. 3 (July, 1965), pp. 364-370.
- Wootton, Barbara. "The Image of the Social Worker," British Journal of Sociology, XI, No. 9 (December 1960), pp. 378-385.

REPORTS

- American Civil Liberties Union of Northern California. The Civil Liberties of Mental Patients: A Proposal for Changes in the California Welfare Code. A report prepared by the Midpeninsula Chapter, 1966.
- California Medical Association. Observations and Comments Based on a Survey of California State Mental Facilities. Submitted to the Department of Mental Hygiene, January 18, 1965.
- Group for the Advancement of Psychiatry. Laws Governing Hospitalization of the Mentally Ill. Report submitted by the Committee on Psychiatry and the Law. VI, No. 61, May 1966, pp. 145-157.
- McCall, Lillian B. Special Report on 'The Long Range Plan for Mental Health Services in California'. A Report submitted to the Assembly Ways and Means Committee. Sacramento, November 1, 1962. (typed draft copy)
- McCall, Lillian B., and John R. Moore. A Proposed Demonstration Project for Comprehensive Community Mental Health Services. A Report submitted to Dr. E.W. Strong, Chancellor, University of California, Berkeley, June 24, 1963.
- Scheff, Thomas J. The Presumption of Illness: Policy Implications of a Field of Study of the Hospitalization and Release of Mental Patients. Report #5 to the Governor's Commission on Mental Health and Illness, State of Wisconsin.

UNPUBLISHED MATERIAL

- Berman, Jerry. Civil Commitment of the Mentally Ill: A

Bibliography Continued

- Need for Reform. An unpublished manuscript available at the California Law Review Office, Boalt Hall, University of California, Berkeley.
- Brill, H. and B. Malzberg. Statistical Report Based on the Arrest Record of 5,354 Ex-Patients Released from New York State Mental Hospital During the Period 1946-1948. An unpublished report available from the authors.
- Deiter, John B., Ph.D., et al. Northwest Washington Hospital-Community Pilot Program. Submitted to the National Institute of Mental Health in application for a Mental Health Project Grant, July 1, 1961.
- Kreplin, Karl W. Mental Illness Commitment: A Study of the Decision-Making Process. A unpublished Masters Thesis, University of California at Santa Barbara, January, 1966.
- Larson, Willard A.E., M.D. "The Positive Self-Fulfilling Prophecy." Presented to the National Institute of Mental Health-U.S.V.A. Research Utilization Conference, December 15-17, 1965, Denver, Colorado.
- Mendel, Werner M., M.D. Brief Hospitalization Techniques. An unpublished paper.
- Miller, Dorothy. Mental Patient Rehospitalization: Triumph Or Disaster? Progress report to the National Institute of Mental Health on NHO 164601, March 1966.
- Miller, Dorothy, et al. "Skiptracers, Investigators, and Social Scientists: Ethics, Problems and Techniques of Follow-up Studies." Paper delivered before the Pacific Sociological Association. Vancouver, British Columbia, April 26, 1966.
- Miller, Dorothy and John Armstrong. A Follow-up Study of Voluntary Admissions: From Screening Unit to State Hospital. Study now in progress, Social Research Laboratory, San Francisco, 1966.
- Roemer, Ruth, LL.B. "Compulsory Hospitalization of the Mentally Ill: Balancing the Interests in Liberty and Health." Paper presented at a seminar on Court Commitment of the Mentally Ill, Metropolitan State Hospital. Norwalk, California, June 25, 1966.
- Scheff, Thomas J. Psychiatric and Social Contingencies and Release Plans for Mental Patients in a Midwestern State. Report, part of a larger study made possible by a grant from Advisory Mental Health Committee of a Midwestern state.
- Wilde, William Austin, Decision Criteria In a Stage of Psychiatric Screening. A thesis submitted in partial satisfaction of the requirements of the degree of Master of Arts in Sociology, University of California, Santa Barbara, June 1966.

OTHER SOURCES

- Daniels, Arlene K., Ph.D., Project Consultant to the United

Bibliography Continued

- States Army Psychiatric Residency Training. Letter to the Subcommittee on Mental Health Services, October 1966.
- Haley, Jay, Editor of Family Process. Letter to the Subcommittee on Mental Health Services, October 24, 1966.
 - Langsley, Donald G., M.D., Director of In-Patient Service, Colorado Psychopathic Hospital. Letter addressed to the Subcommittee on Mental Health Services, July 6, 1966.
 - Lowry, James V., M.D., Director of the Department of Mental Hygiene, California. Letters addressed to Honorable Jerome Waldie, former Member of the California Assembly and Chairman of the Assembly Subcommittee on Mental Health Services, April 21, 1966; and to the Subcommittee on Mental Health Services, October 14, 1966.

